Exhibit 2

UnitedHealthcare Choice Plus

UnitedHealthcare Insurance Company

Certificate of Coverage

For

the Plan 7PB (HDHP $1,500)

of

Insperity Holdings, Inc.

Enrolling Group Number: 701648

Effective Date: January 1, 2013

Offered and Underwritten by

UnitedHealthcare Insurance Company

UnitedHealthcare Insurance Company

185 Asylum Street

Hartford, Connecticut 06103-3408

800-357-1371

IMPORTANT NOTICE

To obtain information or make a complaint, you may call the Company's toll-free number at:

Austin 1-800-424-6480

Dallas 1-800-458-5653

Houston 1-800-548-1078

San Antonio 1-800-842-0174

You may contact the Texas Department of Insurance to obtain information on companies, coverages, rights or complaints at:

1-800-252-3439

You may write the Texas Department of Insurance

P.O. Box 149104

Austin, TX 78714-9104

Fax: (512) 475-1771

Web: http://www.tdi.state.tx.us

E-mail: ConsumerProtection@tdi.state.tx.us

PREMIUM OR CLAIM DISPUTES:

Should you have a dispute concerning your premium or about a claim, you should contact the Company first. If the dispute is not resolved, you may contact the Texas Department of Insurance.

ATTACH THIS NOTICE TO YOUR POLICY:

This notice is for information only and does not become a part or condition of the attached document.

AVISO IMPORTANTE

Para obtener informacion o para someter una queja, usted puede llamar al numero gratis de UnitedHealthcare Insurance Company's para informacion o para someter una queja al:

Austin 1-800-424-6480

Dallas 1-800-458-5653

Houston 1-800-548-1078

San Antonio 1-800-842-0174

Puede comunicarse con el Departmento de Seguros de Texas para obtener informacion acerca de companias, coberturas, derechos o quejas al:

1-800-252-3439

Puede escribir al Departamento de Seguros de Texas

P.O. Box 149104

Austin, TX 78714-9104

Fax: (512) 475-1771

Web: http:www.tdi.state.tx.us

E-mail: ConsumerProtection@tdi.state.tx.us

DISPUTAS AS SOBRE PRIMAS O RECLAMOS:

Si tiene una disputa concerniente a su prima o a un reclamo, debe comunicarse con la Compania primero. Si no se resuelve la disputa, puede entonces comunicarse con el departamento (TDI).

UNA ESTE AVISO A SU POLIZA:

Este aviso es solo para proposito de informacion y no se convierte en parte o condicion del documento adjunto.

Table of Contents

Amendments, Riders and Notices (As Applicable)

UnitedHealthcare Choice Plus

UnitedHealthcare Insurance Company

Schedule of Benefits

Accessing Benefits

You can choose to receive Network Benefits or Non-Network Benefits.

Network Benefits apply to Covered Health Services that are provided by a Network Physician or other Network provider. For facility services, these are Benefits for Covered Health Services that are provided at a Network facility under the direction of either a Network or non-Network Physician or other provider. Network Benefits include Physician services provided in a Network facility by a Network or a non-Network anesthesiologist, Emergency room Physician, consulting Physician, pathologist and radiologist. Emergency Health Services are always paid as Network Benefits.

Non-Network Benefits apply to Covered Health Services that are provided by a non-Network Physician or other non-Network provider, or Covered Health Services that are provided at a non-Network facility.

Depending on the geographic area and the service you receive, you may have access through our Shared Savings Program to non-Network providers who have agreed to discount their charges for Covered Health Services. If you receive Covered Health Services from these providers, the Coinsurance will remain the same as it is when you receive Covered Health Services from non-Network providers who have not agreed to discount their charges; however, the total that you owe may be less when you receive Covered Health Services from Shared Savings Program providers than from other non-Network providers because the Eligible Expense may be a lesser amount.

You must show your identification card (ID card) every time you request health care services from a Network provider. If you do not show your ID card, Network providers have no way of knowing that you are enrolled under a UnitedHealthcare Policy. As a result, they may bill you for the entire cost of the services you receive.

Additional information about the network of providers and how your Benefits may be affected appears at the end of this *Schedule of Benefits*.

If there is a conflict between this *Schedule of Benefits* and any summaries provided to you by the Enrolling Group, this *Schedule of Benefits* will control.

Requests for Pre-authorization of Services

We require a Request for pre-authorization of services before you receive certain Covered Health Services. In general, Network providers are responsible for submitting a Request for pre-authorization of services to us before they provide these services to you. There are some Network Benefits, however, for which you are responsible for submitting a Request for pre-authorization of services to us. If you or your provider fail to submit a Request for pre-authorization of services to us, your Benefits will be paid at 50% of Eligible Expenses, however the reduction in Benefits will not exceed $500.

Services for which you must provide the Request for pre-authorization of services are identified below and in the *Schedule of Benefits* table within each Covered Health Service category.

When you choose to receive certain Covered Health Services from non-Network providers, you are responsible for submitting a Request for pre-authorization of services to us before you receive these services.

When you submit a Request for pre-authorization of services, there are three possible responses you will receive from us:

- A Pre-authorization;
- An Adverse Determination;
- When there are no clinical issues for us to determine, a confirmation of receipt of your request.

Upon receiving your Request for pre-authorization of services and any additional information necessary to complete our review, we will transmit notice of our decision within two working days.

If we issue an Adverse Determination, a written notice regarding the Adverse Determination will be forwarded to you and the provider of record within three business days.

If you are hospitalized at the time of the Adverse Determination, we will provide notice within one business day by either telephone or electronic transmission to the provider of record. Within three business days a written notice will be forwarded to you and the provider of record.

A response will be provided not later than one hour after the time of request for post-stabilization care subsequent to Emergency treatment.

To notify us, call the telephone number for *Customer Care* on your ID card.

Covered Health Services which require a Request for pre-authorization of services:

- Ambulance - non-emergent air and ground.
- Autism Spectrum Disorders.
- Clinical trials.
- Congenital heart disease surgery.
- Dental services - accidental.
- Developmental delay services.
- Diabetes equipment - insulin pumps over $1,000.
- Durable Medical Equipment over $1,000.
- Home health care.
- Hospice care - inpatient.
- Hospital inpatient care - all scheduled admissions and maternity stays exceeding 48 hours for an uncomplicated normal vaginal delivery or 96 hours for an uncomplicated cesarean section delivery and stays for Complications of Pregnancy exceeding 96 hours.
- Mental Health Services.
- Neurobiological Disorders - Autism Spectrum Disorder Services.
- Reconstructive procedures.
- Rehabilitation services and Manipulative Treatment - Manipulative Treatment.
- Skilled Nursing Facility and Inpatient Rehabilitation Facility services.
- Substance use disorder services.
- Temporomandibular joint services.

- Therapeutics - only for the following services: dialysis.
- Transplants.

For all other services, when you choose to receive services from non-Network providers, we urge you to confirm with us that the services you plan to receive are Covered Health Services. That's because in some instances, certain procedures may not meet the definition of a Covered Health Service and therefore are excluded. In other instances, the same procedure may meet the definition of Covered Health Services. By calling before you receive treatment, you can check to see if the service is subject to limitations or exclusions.

If you request a coverage determination at the time notice is provided, the determination will be made based on the services you report you will be receiving. If the reported services differ from those actually received, our final coverage determination will be modified to account for those differences, and we will only pay Benefits based on the services actually delivered to you.

Care Coordination[SM]

When a Request for pre-authorization of services is submitted as required, we will work with you to implement the Care Coordination[SM] process and to provide you with information about additional services that are available to you, such as disease management programs, health education, and patient advocacy.

Special Note Regarding Medicare

If you are enrolled in Medicare on a primary basis (Medicare pays before we pay Benefits under the Policy), the Request for pre-authorization of services requirements do not apply to you. Since Medicare is the primary payer, we will pay as secondary payer as described in *Section 7: Coordination of Benefits*. You are not required to submit a Request for pre-authorization of services to us before receiving Covered Health Services.

Benefits

Annual Deductibles are calculated on a calendar year basis.

Out-of-Pocket Maximums are calculated on a calendar year basis.

When Benefit limits apply, the limit stated refers to any combination of Network Benefits and Non-Network Benefits unless otherwise specifically stated.

Benefit limits are calculated on a calendar year basis unless otherwise specifically stated.

Payment Term And Description	**Amounts**
Annual Deductible	
The amount of Eligible Expenses you pay for Covered Health Services per year before you are eligible to receive Benefits. The Annual Deductible applies to Covered Health Services under the Policy as indicated in this *Schedule of Benefits*, including Covered Health Services provided under the *Outpatient Prescription Drug Rider.* The Annual Deductible for Network Benefits includes the amount you pay for both Network and Non-Network Benefits for outpatient prescription drug products provided under the *Outpatient Prescription Drug Rider.*	***Network*** For single coverage, the Annual Deductible is $1,500 per Covered Person. If more than one person in a family is covered under the Policy, the single coverage Annual Deductible stated above does not apply. For family coverage, the family Annual Deductible is $3,000. No one in the

Payment Term And Description	Amounts
Amounts paid toward the Annual Deductible for Covered Health Services that are subject to a visit or day limit will also be calculated against that maximum Benefit limit. As a result, the limited Benefit will be reduced by the number of days/visits used toward meeting the Annual Deductible. When a Covered Person was previously covered under a group policy that was replaced by the group Policy, any amount already applied to that annual deductible provision of the prior policy will apply to the Annual Deductible provision under the Policy. The amount that is applied to the Annual Deductible is calculated on the basis of Eligible Expenses. The Annual Deductible does not include any amount that exceeds Eligible Expenses. Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table.	family is eligible to receive Benefits until the family Annual Deductible is satisfied. ***Non-Network*** For single coverage, the Annual Deductible is $3,000 per Covered Person. If more than one person in a family is covered under the Policy, the single coverage Annual Deductible stated above does not apply. For family coverage, the family Annual Deductible is $6,000. No one in the family is eligible to receive Benefits until the family Annual Deductible is satisfied.
Out-of-Pocket Maximum	
The maximum you pay per year for the Annual Deductible, or Coinsurance. Once you reach the Out-of-Pocket Maximum, Benefits are payable at 100% of Eligible Expenses during the rest of that year. The Out-of-Pocket Maximum applies to Covered Health Services under the Policy as indicated in this *Schedule of Benefits*, including Covered Health Services provided under the *Outpatient Prescription Drug Rider.* The Out-of-Pocket Maximum for Network Benefits includes the amount you pay for both Network and Non-Network Benefits for outpatient prescription drug products provided under the *Outpatient Prescription Drug Rider.* Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table. The Out-of-Pocket Maximum does not include any of the following and, once the Out-of-Pocket Maximum has been reached, you still will be required to pay the following: • Any charges for non-Covered Health Services. • The amount Benefits are reduced if you do not submit a Request for pre-authorization of services to us as required. • Charges that exceed Eligible Expenses. • Copayments or Coinsurance for any Covered Health Service identified in the *Schedule of Benefits* table that does not apply to the Out-of-Pocket Maximum.	***Network*** For single coverage, the Out-of-Pocket Maximum is $3,000 per Covered Person. If more than one person in a family is covered under the Policy, the single coverage Out-of-Pocket Maximum stated above does not apply. For family coverage, the family Out-of-Pocket Maximum is $6,000. The Out-of-Pocket Maximum includes the Annual Deductible. ***Non-Network*** For single coverage, the Out-of-Pocket Maximum is $6,000 per Covered Person. If more than one person in a family is covered under the Policy, the single coverage Out-of-Pocket Maximum stated above does not apply. For family coverage, the family Out-of-Pocket Maximum is $12,000. The Out-of-Pocket Maximum includes the Annual Deductible.
Maximum Policy Benefit	
The maximum amount we will pay for Benefits during the	***Network***

Payment Term And Description	Amounts
entire period of time you are enrolled under the Policy.	No Maximum Policy Benefit. ***Non-Network*** No Maximum Policy Benefit.
Copayment	
Copayment is the amount you pay (calculated as a set dollar amount) each time you receive certain Covered Health Services. When Copayments apply, the amount is listed on the following pages next to the description for each Covered Health Service. Please note that for Covered Health Services, you are responsible for paying the lesser of: • The applicable Copayment. • The Eligible Expense. Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table.	
Coinsurance	
Coinsurance is the amount you pay (calculated as a percentage of Eligible Expenses) each time you receive certain Covered Health Services. Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table.	

Benefit Limits

This Benefit plan does not have Benefit limits in addition to those stated below within the Covered Health Service categories in the *Schedule of Benefits* table.

When Benefit limits apply, the limit refers to any combination of Network Benefits and Non-Network Benefits unless otherwise specifically stated.			
Covered Health Service	**Benefit** ***(The Amount We Pay, based on Eligible Expenses)***	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
1. Ambulance Services			
Request for Pre-Authorization of Services Requirement In most cases, we will initiate and direct non-Emergency ambulance transportation. If you are requesting non-Emergency ambulance services, you must submit a Request for pre-authorization of services to us as soon as possible prior to transport. If you fail to submit a Request for pre-authorization of services to us as required, Benefits will be reduced to 50% of Eligible Expenses, however the reduction in Benefits will not exceed $500.			
Emergency Ambulance	***Network*** *Ground Ambulance:* 90% *Air Ambulance:* 90% ***Non-Network*** Same as Network	 Yes Yes Same as Network	 Yes Yes Same as Network
Non-Emergency Ambulance Ground or air ambulance, as we determine appropriate.	***Network*** *Ground Ambulance:* 90% *Air Ambulance:* 90% ***Non-Network*** Same as Network	 Yes Yes Same as Network	 Yes Yes Same as Network
2. Clinical Trials			
Request for Pre-Authorization of Services Requirement You must submit a Request for pre-authorization of services to us as soon as the possibility of participation in a clinical trial arises. If you don't submit a Request for pre-authorization of services to us, Benefits will be reduced to 50% of Eligible Expenses, however the reduction in Benefits will not exceed $500.			
Depending upon the Covered Health Service, Benefit limits are the same as those stated under the specific Benefit category in this *Schedule of Benefits*.	***Network*** Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*.		

When Benefit limits apply, the limit refers to any combination of Network Benefits and Non-Network Benefits unless otherwise specifically stated.			
Covered Health Service	**Benefit** ***(The Amount We Pay, based on Eligible Expenses)***	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
Network Benefits are available when the Covered Health Services are provided by either Network or non-Network providers, however the non-Network provider must agree to accept the Network level of reimbursement by signing a network provider agreement specifically for the patient enrolling in the trial. (Network Benefits are not available if the non-Network provider does not agree to accept the Network level of reimbursement and in that case, Non-Network Benefits will apply.)	***Non-Network*** Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*.		
3. Congenital Heart Disease Surgeries			
Request for Pre-Authorization of Services Requirement For Non-Network Benefits you must submit a Request for pre-authorization of services to us as soon as the possibility of a Congenital Heart Disease (CHD) surgery arises. If you don't submit a Request for pre-authorization of services to us, Benefits will be reduced to 50% of Eligible Expenses, however the reduction in Benefits will not exceed $500.			
Network and Non-Network Benefits under this section include only the Congenital Heart Disease (CHD) surgery. Depending upon where the Covered Health Service is provided, Benefits for diagnostic services, cardiac catheterization and non-surgical management of CHD will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*. Non-Network Benefits are limited to $30,000 per CHD surgery.	***Network*** 90% ***Non-Network*** 70%	Yes Yes	Yes Yes
4. Dental Services - Accident Only			
Request for Pre-Authorization of Services Requirement For Network and Non-Network Benefits you must submit a Request for pre-authorization of services to us five business days or as soon as is reasonably possible before follow-up (post-Emergency) treatment begins. (You do not have to submit a Request for pre-authorization of services to us before the initial Emergency treatment.) If you fail to submit a Request for pre-authorization of services to us as required, Benefits will be reduced to 50% of Eligible Expenses, however the reduction in Benefits			

When Benefit limits apply, the limit refers to any combination of Network Benefits and Non-Network Benefits unless otherwise specifically stated.			
Covered Health Service	**Benefit** ***(The Amount We Pay, based on Eligible Expenses)***	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
will not exceed $500.			
Limited to $3,000 per year. Benefits are further limited to a maximum of $900 per tooth.	***Network*** 90% ***Non-Network*** Same as Network	 Yes Same as Network	 Yes Same as Network
5. Diabetes Services			
Request for Pre-Authorization of Services Requirement For Non-Network Benefits you must submit a Request for pre-authorization of services to us before obtaining any diabetes equipment for the management and treatment of diabetes that exceeds $1,000 in cost (either purchase price or cumulative rental of a single item). If you fail to submit a Request for pre-authorization of services to us as required, Benefits will be reduced to 50% of Eligible Expenses, however the reduction in Benefits will not exceed $500.			
Diabetes Self-Management and Training/Diabetic Eye Examinations/Foot Care	***Network*** Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management and training/diabetic eye examinations/foot care will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*. ***Non-Network*** Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management and training/diabetic eye examinations/foot care will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*.		
Diabetes Self-Management Items Benefits for diabetes equipment that meets the definition of Durable Medical Equipment are not subject to the limit stated under *Durable Medical Equipment.* Benefits for podiatric appliances are limited to two pairs of therapeutic footwear per year for the prevention of complications associated with diabetes.	***Network*** Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management items will be the same as those stated under *Durable Medical Equipment* and in the *Outpatient Prescription Drug Rider.* ***Non-Network***		

When Benefit limits apply, the limit refers to any combination of Network Benefits and Non-Network Benefits unless otherwise specifically stated.			
Covered Health Service	**Benefit** ***(The Amount We Pay, based on Eligible Expenses)***	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management items will be the same as those stated under *Durable Medical Equipment* and in the *Outpatient Prescription Drug Rider.*		
6. Durable Medical Equipment			
Request for Pre-Authorization of Services Requirement For Non-Network Benefits you must submit a Request for pre-authorization of services to us before obtaining any Durable Medical Equipment that exceeds $1,000 in cost (either purchase price or cumulative rental of a single item). If you fail to submit a Request for pre-authorization of services to us as required, Benefits will be reduced to 50% of Eligible Expenses, however the reduction in Benefits will not exceed $500.			
Limited to $3,500 in Eligible Expenses per year. Benefits are limited to a single purchase of a type of DME (including repair/replacement) every two years. Benefits for speech aid devices and tracheo-esophageal voice devices are limited to the purchase of one device during the entire period of time a Covered Person is enrolled under the Policy. Benefits for repair/replacement are limited to once every three years. Speech aid and tracheo-esophageal voice devices are included in the annual limits stated above. To receive Network Benefits, you must purchase or rent the Durable Medical Equipment from the vendor we identify or purchase it directly from the prescribing Network Physician.	***Network*** 90% ***Non-Network*** 70%	Yes Yes	Yes Yes
7. Emergency Health Services - Outpatient			
Note: If you are confined in a non-Network Hospital after you receive outpatient Emergency Health Services, you must submit a Request for pre-authorization of services to us within one business day or on the	***Network*** 90%	Yes	Yes

When Benefit limits apply, the limit refers to any combination of Network Benefits and Non-Network Benefits unless otherwise specifically stated.			
Covered Health Service	**Benefit** ***(The Amount We Pay, based on Eligible Expenses)***	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
same day of admission or as soon as reasonably possible. We may elect to transfer you to a Network Hospital as soon as it is medically appropriate to do so. If you choose to stay in the non-Network Hospital after the date we decide a transfer is medically appropriate, Network Benefits will not be provided. Non-Network Benefits will be available if the continued stay is determined to be a Covered Health Service.	***Non-Network*** Same as Network	Same as Network	Same as Network
8. Hearing Aids			
Benefits are limited to a single purchase (including repair/replacement) every two years.	***Network*** 90%	Yes	Yes
	Non-Network 70%	Yes	Yes
9. Home Health Care			
Request for Pre-Authorization of Services Requirement For Non-Network Benefits you must submit a Request for pre-authorization of services to us five business days before receiving services or as soon as is reasonably possible. If you fail to submit a Request for pre-authorization of services to us as required, Benefits will be reduced to 50% of Eligible Expenses, however the reduction in Benefits will not exceed $500.			
Limited to 60 visits per year. One visit equals up to four hours of skilled care services. This visit limit does not include any service which is billed only for the administration of intravenous infusion.	***Network*** 90%	Yes	Yes
	Non-Network 70%	Yes	Yes
10. Hospice Care			

When Benefit limits apply, the limit refers to any combination of Network Benefits and Non-Network Benefits unless otherwise specifically stated.			
Covered Health Service	**Benefit** ***(The Amount We Pay, based on Eligible Expenses)***	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
Request for Pre-Authorization of Services Requirement For Non-Network Benefits you must submit a Request for pre-authorization of services to us five business days before admission for an Inpatient Stay in a hospice facility or as soon as is reasonably possible. If you fail to submit a Request for pre-authorization of services to us as required, Benefits will be reduced to 50% of Eligible Expenses, however the reduction in Benefits will not exceed $500. In addition, for Non-Network Benefits, you must submit a Request for pre-authorization of services to us within 24 hours of admission or as soon as is reasonably possible for an Inpatient Stay in a hospice facility.			
	Network 90% ***Non-Network*** 70%	 Yes Yes	 Yes Yes
11. Hospital - Inpatient Stay			
Request for Pre-Authorization of Services Requirement For Non-Network Benefits for a scheduled admission, you must submit a Request for pre-authorization of services to us five business days before admission, or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions). If you fail to submit a Request for pre-authorization of services to us as required, Benefits will be reduced to 50% of Eligible Expenses, however the reduction in Benefits will not exceed $500. In addition, for Non-Network Benefits you must submit a Request for pre-authorization of services to us 24 hours before admission for scheduled admissions or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions).			
	Network 90% ***Non-Network*** 70%	 Yes Yes	 Yes Yes
12. Lab, X-Ray and Diagnostics - Outpatient			
	Network 90% ***Non-Network*** 70%	 Yes Yes	 Yes Yes

When Benefit limits apply, the limit refers to any combination of Network Benefits and Non-Network Benefits unless otherwise specifically stated.			
Covered Health Service	**Benefit** ***(The Amount We Pay, based on Eligible Expenses)***	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
13. Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient			
	Network 90% ***Non-Network*** 70%	 Yes Yes	 Yes Yes
14. Mental Health Services			
Request for Pre-Authorization of Services Requirement You must submit a Request for pre-authorization of services to us in order to receive Benefits. If you fail to submit a Request for pre-authorization of services to us as required, Benefits will be reduced to 50% of Eligible Expenses, however the reduction in Benefits will not exceed $500.			
	Network *Inpatient/Intermediate* 90% *Outpatient* 90% ***Non-Network*** *Inpatient/Intermediate* 70% *Outpatient* 70%	 Yes Yes Yes Yes	 Yes Yes Yes Yes
15. Neurobiological Disorders - Autism Spectrum Disorder Services			
Request for Pre-Authorization of Services Requirement You must submit a Request for pre-authorization of services to us in order to receive Benefits. If you fail to submit a Request for pre-authorization of services to us as required, Benefits will be reduced to 50% of Eligible Expenses, however the reduction in Benefits will not exceed $500.			
	Network *Inpatient/Intermediate*		

When Benefit limits apply, the limit refers to any combination of Network Benefits and Non-Network Benefits unless otherwise specifically stated.			
Covered Health Service	**Benefit** ***(The Amount We Pay, based on Eligible Expenses)***	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	90% *Outpatient* 90% ***Non-Network*** *Inpatient/Intermediate* 70% *Outpatient* 70%	Yes Yes Yes Yes	Yes Yes Yes Yes
16. Ostomy Supplies			
Limited to $2,500 per year.	***Network*** 90% ***Non-Network*** 70%	 Yes Yes	 Yes Yes
17. Pharmaceutical Products - Outpatient			
	Network 90% ***Non-Network*** 70%	 Yes Yes	 Yes Yes
18. Physician Fees for Surgical and Medical Services			
	Network 90% ***Non-Network*** 70%	 Yes Yes	 Yes Yes
19. Physician's Office Services - Sickness and Injury			
	Network 90%	 Yes	 Yes

When Benefit limits apply, the limit refers to any combination of Network Benefits and Non-Network Benefits unless otherwise specifically stated.			
Covered Health Service	**Benefit** ***(The Amount We Pay, based on Eligible Expenses)***	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	Non-Network 70%	Yes	Yes
20. Pregnancy - Maternity Services and Complications of Pregnancy			
Request for Pre-Authorization of Services Requirement For Non-Network Benefits you must submit a Request for pre-authorization of services to us as soon as reasonably possible if the Inpatient Stay for the mother and/or the newborn will be more than 48 hours for the mother and newborn child following an uncomplicated normal vaginal delivery, or more than 96 hours for the mother and newborn child following an uncomplicated cesarean section delivery. If you fail to submit a Request for pre-authorization of services to us as required, Benefits will be reduced to 50% of Eligible Expenses, however the reduction in Benefits will not exceed $500. **It is important that you submit a Request for pre-authorization of services to us regarding your Pregnancy. Your Request for pre-authorization of services will open the opportunity to become enrolled in prenatal programs that are designed to achieve the best outcomes for you and your baby.**			
	Network Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits* except that an Annual Deductible will not apply for a newborn child whose length of stay in the Hospital is the same as the mother's length of stay. ***Non-Network*** Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits* except that an Annual Deductible will not apply for a newborn child whose length of stay in the Hospital is the same as the mother's length of stay.		
21. Preventive Care Services			
Physician office services Immunizations for Enrolled Dependent children up to age 6 are not subject to payment of any Annual Deductible or to any Copayment or Coinsurance requirements. Screening tests for hearing loss for newborn Dependents from birth through the date the child is 30 days old and diagnostic follow-up care relating to the screening test from	***Network*** 100%	No	No

When Benefit limits apply, the limit refers to any combination of Network Benefits and Non-Network Benefits unless otherwise specifically stated.			
Covered Health Service	**Benefit** ***(The Amount We Pay, based on Eligible Expenses)***	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
birth through 24 months are not subject to payment of any Annual Deductible. **Lab, X-ray or other preventive tests**	***Non-Network*** 70% ***Network*** 100% ***Non-Network*** 70%	Yes No Yes	Yes No Yes
22. Prosthetic Devices			
Limited to $3,500 per year. Benefits are limited to a single purchase of each type of prosthetic device every two years. Benefits including breast prosthetics are available for items required by the *Women's Health and Cancer Rights Act of 1998.* Breast prosthetics are not limited, however the cost of breast prosthetics is applied to the maximum.	***Network*** 90% ***Non-Network*** 70%	Yes Yes	Yes Yes
23. Prosthetic Devices and Orthotic Devices - Artificial Arms and Legs			
Benefits are limited to a single purchase of each type of prosthetic or orthotic device every three years.	***Network*** 90% ***Non-Network*** 70%	Yes Yes	Yes Yes
24. Reconstructive Procedures			
Request for Pre-Authorization of Services Requirement For Non-Network Benefits you must submit a Request for pre-authorization of services to us five business days before a scheduled reconstructive procedure is performed or, for non-scheduled procedures, within one business day or as soon as is reasonably possible. If you fail to submit a Request for pre-authorization of services to us as required, Benefits will be reduced to 50% of Eligible Expenses, however the Benefits reduction will not exceed $500.			

When Benefit limits apply, the limit refers to any combination of Network Benefits and Non-Network Benefits unless otherwise specifically stated.			
Covered Health Service	**Benefit** ***(The Amount We Pay, based on Eligible Expenses)***	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
In addition, for Non-Network Benefits you must submit a Request for pre-authorization of services to us 24 hours before admission for scheduled inpatient admissions or as soon as is reasonably possible for non-scheduled inpatient admissions (including Emergency admissions).			
	Network Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*. ***Non-Network*** Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*.		
25. Rehabilitation Services - Outpatient Therapy and Manipulative Treatment			
Request for Pre-Authorization of Services Requirement For Non-Network Benefits you must submit a Request for pre-authorization of services to us five business days before receiving Manipulative Treatment or as soon as is reasonably possible. If you fail to submit a Request for pre-authorization of services to us as required, Benefits will be reduced to 50% of Eligible Expenses, however the reduction in Benefits will not exceed $500.			
Limited per year as follows: • 20 visits of physical therapy. • 20 visits of occupational therapy. • 24 visits of Manipulative Treatment. • Unlimited visits of speech therapy. • 20 visits of pulmonary rehabilitation therapy. • 36 visits of cardiac rehabilitation therapy. • 30 visits of post-cochlear implant aural therapy.	***Network*** 90%	Yes	Yes

When Benefit limits apply, the limit refers to any combination of Network Benefits and Non-Network Benefits unless otherwise specifically stated.			
Covered Health Service	**Benefit** ***(The Amount We Pay, based on Eligible Expenses)***	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	Non-Network 70%	Yes	Yes
26. Scopic Procedures - Outpatient Diagnostic and Therapeutic			
	Network 90% ***Non-Network*** 70%	Yes Yes	Yes Yes
27. Skilled Nursing Facility/Inpatient Rehabilitation Facility Services			
Request for Pre-Authorization of Services Requirement For Non-Network Benefits for a scheduled admission, you must submit a Request for pre-authorization of services to us five business days before admission, or as soon as is reasonably possible for non-scheduled admissions. If you fail to submit a Request for pre-authorization of services to us as required, Benefits will be reduced to 50% of Eligible Expenses, however the Benefits reduction will not exceed $500. In addition, for Non-Network Benefits you must submit a Request for pre-authorization of services to us 24 hours before admission for scheduled admissions or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions).			
Limited to 120 days per year.	***Network*** 90% ***Non-Network*** 70%	Yes Yes	Yes Yes
28. Substance Use Disorder Services			
Request for Pre-Authorization of Services Requirement You must submit a Request for pre-authorization of services to us in order to receive Benefits. If you fail to submit a Request for pre-authorization of services to us as required, Benefits will be reduced to 50% of Eligible Expenses, however the reduction in Benefits will not exceed $500.			
	Network *Inpatient/Intermediate* 90%	Yes	Yes

When Benefit limits apply, the limit refers to any combination of Network Benefits and Non-Network Benefits unless otherwise specifically stated.			
Covered Health Service	**Benefit** ***(The Amount We Pay, based on Eligible Expenses)***	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	Outpatient 90% ***Non-Network*** *Inpatient/Intermediate* 70% *Outpatient* 70%	 Yes Yes Yes	 Yes Yes Yes
29. Surgery - Outpatient			
	Network 90% ***Non-Network*** 70%	 Yes Yes	 Yes Yes
30. Temporomandibular Joint Services			
Request for Pre-Authorization of Services Requirement For Non-Network Benefits you must submit a Request for pre-authorization of services to us five business days or as soon as reasonably possible before temporomandibular joint services are performed during an Inpatient Stay in a Hospital. If you fail to submit a Request for pre-authorization of services to us as required, Benefits will be reduced to 50% of Eligible Expenses, however the reduction in Benefits will not exceed $500.			
	Network Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*. ***Non-Network*** Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*.		
31. Therapeutic Treatments - Outpatient			
Request for Pre-Authorization of Services Requirement			

When Benefit limits apply, the limit refers to any combination of Network Benefits and Non-Network Benefits unless otherwise specifically stated.			
Covered Health Service	**Benefit** ***(The Amount We Pay, based on Eligible Expenses)***	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
For Non-Network Benefits you must submit a Request for pre-authorization of services to us for the following outpatient therapeutic services five business days before scheduled services are received or, for non-scheduled services, within one business day or as soon as is reasonably possible. Services that require a Request for pre-authorization of services: dialysis. If you fail to submit a Request for pre-authorization of services to us as required, Benefits will be reduced to 50% of Eligible Expenses, however the Benefits reduction will not exceed $500.			
	Network 90% ***Non-Network*** 70%	 Yes Yes	 Yes Yes
32. Transplantation Services			
Request for Pre-Authorization of Services Requirement For Network Benefits you must submit a Request for pre-authorization of services to us as soon as the possibility of a transplant arises (and before the time a pre-transplantation evaluation is performed at a transplant center). If you don't submit a Request for pre-authorization of services to us and if, as a result, the services are not performed at a Designated Facility, Network Benefits will not be paid. Non-Network Benefits will apply. For Non-Network Benefits you must submit a Request for pre-authorization of services to us as soon as the possibility of a transplant arises (and before the time a pre-transplantation evaluation is performed at a transplant center). If you fail to submit a Request for pre-authorization of services to us as required, Benefits will be reduced to 50% of Eligible Expenses, however the reduction in Benefits will not exceed $500. In addition, for Non-Network Benefits you must submit a Request for pre-authorization of services to us 24 hours before admission for scheduled admissions or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions).			
For Network Benefits, transplantation services must be received at a Designated Facility. We will refer you to the Designated Facility most suitable, in our opinion, to treat your condition. In the event that the selected Designated Facility is located outside of Texas and you do not wish to travel outside the state, we shall refer you to an alternate Designated Facility within the State of Texas. We do not require that cornea transplants be performed at a Designated Facility in order for you to receive Network Benefits.	***Network*** 90%	 Yes	 Yes

When Benefit limits apply, the limit refers to any combination of Network Benefits and Non-Network Benefits unless otherwise specifically stated.			
Covered Health Service	**Benefit** ***(The Amount We Pay, based on Eligible Expenses)***	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
Non-Network Benefits are limited to $30,000 per transplant.	***Non-Network*** 70%	Yes	Yes
33. Urgent Care Center Services			
	Network 90% ***Non-Network*** 70%	Yes Yes	Yes Yes
34. Vision Examinations			
Limited to 1 exam every 2 years.	***Network*** 90% ***Non-Network*** 70%	Yes Yes	Yes Yes
Additional Benefits Required By Texas Law			
35. Acquired Brain Injury			
Request for Pre-Authorization of Services Requirement Depending upon where the Covered Health Service is provided, any applicable Request for pre-authorization of services or authorization requirements will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*.			
Outpatient Post-acute Transition Services and Post-acute Care Treatment Services: See the section for Rehabilitative Services - Outpatient Therapy and Manipulative Treatment in this Schedule of Benefits for physical therapy, occupational therapy, Manipulative Treatment and speech therapy limits.	***Network*** 90% ***Non-Network*** 70%	Yes Yes	Yes Yes
Inpatient Post-acute Transition Services and Post-acute Care	***Network***		

When Benefit limits apply, the limit refers to any combination of Network Benefits and Non-Network Benefits unless otherwise specifically stated.			
Covered Health Service	**Benefit** ***(The Amount We Pay, based on Eligible Expenses)***	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
Treatment Services are limited as follows: Limited to 60 days per year.	90% ***Non-Network*** 70%	Yes Yes	Yes Yes
For all other Covered Health Services, coverage for acquired brain injury will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*. Covered Health Services for Post-acute Care Treatment Services and Post-acute Transition Services are the same as any other illness or Injury and subject to limits as stated under each category in this *Schedule of Benefits*.	***Network*** Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*. ***Non-Network*** Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*.		
36. Amino Acid-Based Elemental Formulas			
	Network If an *Outpatient Prescription Drug Rider* is included under this Policy, Benefits for the amino acid-based elemental formulas will be provided as described under the *Outpatient Prescription Drug Rider*. Otherwise, Benefits will be provided under this Policy, and depending upon where the Covered Health Service is provided, Benefits will be the same as stated under each Covered Health Service category in this *Schedule of Benefits*. ***Non-Network*** If an *Outpatient Prescription Drug Rider* is included under this Policy, Benefits for the amino acid-based elemental formulas will be provided as described under the *Outpatient Prescription Drug Rider*. Otherwise, Benefits will be provided under this Policy, and depending upon where the Covered Health Service is provided, Benefits will be the same as stated		

When Benefit limits apply, the limit refers to any combination of Network Benefits and Non-Network Benefits unless otherwise specifically stated.			
Covered Health Service	**Benefit** ***(The Amount We Pay, based on Eligible Expenses)***	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	under each Covered Health Service category in this *Schedule of Benefits*.		
37. Autism Spectrum Disorders			
Request for Pre-Authorization of Services Requirement For Non-Network Benefits you must submit a Request for pre-authorization of services to us five business days before scheduled services are received or, for non-scheduled services, within one business day or as soon as is reasonably possible. If you fail to submit a Request for pre-authorization of services to us as required, Benefits will be reduced to 50% of Eligible Expenses, however the reduction in Benefits will not exceed $500.			
	Network Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*, except that any visit limits are not applicable to Covered Health Services related to the treatment of Autism Spectrum Disorders. ***Non-Network*** Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*, except that any visit limits are not applicable to Covered Health Services related to the treatment of Autism Spectrum Disorders.		
38. Developmental Delay Services			
Benefits are paid at the same level as Benefits for any other Covered Health Service, except that the Benefit limit for *Rehabilitation Services - Outpatient Therapy and Manipulative Treatment* does not apply to services for developmental delays.	***Network*** Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*. ***Non-Network*** Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*.		
39. Speech and Hearing Services			
Benefits are paid at the same level as	***Network***		

When Benefit limits apply, the limit refers to any combination of Network Benefits and Non-Network Benefits unless otherwise specifically stated.			
Covered Health Service	**Benefit** ***(The Amount We Pay, based on Eligible Expenses)***	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
Benefits for any other Covered Health Service, except that the Benefit limit for *Rehabilitation Services - Outpatient Therapy and Manipulative Treatment* does not apply to speech and hearing services. **Hearing Aids and Fittings**: Benefits for the purchase or fitting of hearing aids are not provided under this Covered Health Service category, but are instead provided under the Hearing Aids category in this *Schedule of Benefits*.	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*. ***Non-Network*** Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*.		

Eligible Expenses

Eligible Expenses are the amount we determine that we will pay for Benefits. For Network Benefits, you are not responsible for any difference between Eligible Expenses and the amount the provider bills. For Non-Network Benefits, you are responsible for paying, directly to the non-Network provider, any difference between the amount the provider bills you and the amount we will pay for Eligible Expenses. Eligible Expenses are determined in accordance with our reimbursement policy guidelines, as described in the *Certificate*.

For Network Benefits, Eligible Expenses are based on either of the following:

- When Covered Health Services are received from a Network provider, Eligible Expenses are our contracted fee(s) with that provider.
- When Covered Health Services are received from a non-Network provider as a result of an Emergency or as otherwise arranged by us, Eligible Expenses are billed charges unless a lower amount is negotiated.

For Non-Network Benefits, Eligible Expenses are based on either of the following:

- When Covered Health Services are received from a non-Network provider, Eligible Expenses are determined, at our discretion, based on the lesser of:
  - Fee(s) that are negotiated with the provider.
  - 110% of the published rates allowed by the *Centers for Medicare and Medicaid Services (CMS)* for Medicare for the same or similar service within the geographic market.
  - 50% of the billed charge.

  - A fee schedule that we develop.

- When Covered Health Services are received from a Network provider, Eligible Expenses are our contracted fee(s) with that provider.

Provider Network

We arrange for health care providers to participate in a Network. Network providers are independent practitioners. They are not our employees. It is your responsibility to select your provider.

Our credentialing process confirms public information about the providers' licenses and other credentials, but does not assure the quality of the services provided.

Before obtaining services you should always verify the Network status of a provider. A provider's status may change. You can verify the provider's status by calling *Customer Care*. A directory of providers is available online at www.myuhc.com or by calling *Customer Care* at the telephone number on your ID card to request a copy.

It is possible that you might not be able to obtain services from a particular Network provider. The network of providers is subject to change. Or you might find that a particular Network provider may not be accepting new patients. If a provider leaves the Network or is otherwise not available to you, you must choose another Network provider to get Network Benefits.

If you are currently undergoing a course of treatment utilizing a non-Network Physician or health care facility, you may be eligible to receive transition of care Benefits. This transition period is available for specific medical services and for limited periods of time. If you have questions regarding this transition of care reimbursement policy or would like help determining whether you are eligible for transition of care Benefits, please contact *Customer Care* at the telephone number on your ID card.

Do not assume that a Network provider's agreement includes all Covered Health Services. Some Network providers contract with us to provide only certain Covered Health Services, but not all Covered Health Services. Some Network providers choose to be a Network provider for only some of our products. Refer to your provider directory or contact us for assistance.

Designated Facilities and Other Providers

If you have a medical condition that we believe needs special services, we may direct you to a Designated Facility or Designated Physician chosen by us. If you require certain complex Covered Health Services for which expertise is limited, we may direct you to a Network facility or provider that is outside your local geographic area. If you are required to travel to obtain such Covered Health Services from a Designated Facility or Designated Physician, we may reimburse certain travel expenses at our discretion.

You or your Network Physician must submit a Request for pre-authorization of services to us of special service needs (such as transplants or cancer treatment) that might warrant referral to a Designated Facility or Designated Physician. If you do not submit a Request for pre-authorization of services to us in advance, and if you receive services from a non-Network facility (regardless of whether it is a Designated Facility) or other non-Network provider, Network Benefits will be reduced to 50% of Eligible Expenses, however the reduction in Benefits will not exceed $500. Non-Network Benefits will be available if the special needs services you receive are Covered Health Services for which Benefits are provided under the Policy.

Health Services from Non-Network Providers Paid as Network Benefits

If specific Covered Health Services are not available from a Network provider, you may be eligible for Network Benefits when Covered Health Services are received from non-Network providers. In this

situation, your Network Physician will submit a Request for pre-authorization of services to us and, if we confirm that care is not available from a Network provider, we will work with you and your Network Physician to coordinate care through a non-Network provider.

Continuity of Care

If you are undergoing a course of treatment from a Network provider at the time that Network provider is no longer contracted with us, you may be entitled to continue that care covered at the Network Benefit level. Continuity of care is available in special circumstances in which the treating Physician or health care provider reasonably believes discontinuing care by the treating Physician could cause harm to the Covered Person. Special circumstances include Covered Persons with a disability acute condition, life-threatening illness or past the 24th week of Pregnancy. The continuity of care request must be submitted by the treating Physician or provider. If continuity of care is approved, it may not be continued beyond 90 days after the Physician or provider is no longer contracted with us, if the Covered Person has been diagnosed as having a terminal illness at the time of the termination, or the expiration of the nine month period after the effective date of the termination. If the Covered Person is past the 24th week of Pregnancy at the time of termination, coverage at the Network level will continue through the delivery of the child, immediate postpartum care and the follow-up checkup within the six week period after delivery. If you have questions regarding this transition of care reimbursement policy or would like help determining whether you are eligible for transition of care Benefits, please contact Customer Care at the telephone number on your ID card.

Certificate of Coverage

UnitedHealthcare Insurance Company

Certificate of Coverage is Part of Policy

This *Certificate of Coverage* (*Certificate*) is part of the Policy that is a legal document between UnitedHealthcare Insurance Company and the Enrolling Group to provide Benefits to Covered Persons, subject to the terms, conditions, exclusions and limitations of the Policy. We issue the Policy based on the Enrolling Group's application and payment of the required Policy Charges.

In addition to this *Certificate* the Policy includes:

- The *Group Policy*.
- The *Schedule of Benefits*.
- The Enrolling Group's application.
- Riders.
- Amendments.

You can review the Policy at the office of the Enrolling Group during regular business hours.

Changes to the Document

We may from time to time modify this *Certificate* by attaching legal documents called Riders and/or Amendments that may change certain provisions of this *Certificate*. When that happens we will send you a new *Certificate*, Rider or Amendment pages.

No one can make any changes to the Policy unless those changes are in writing and agreed to by the Enrolling Group or required by state or federal law.

Other Information You Should Have

We have the right to change, interpret, modify, withdraw or add Benefits, or to terminate the Policy, as permitted by law, without the Subscriber's approval.

On its effective date, this *Certificate* replaces and overrules any *Certificate* that we may have previously issued to you. This *Certificate* will in turn be overruled by any *Certificate* we issue to you in the future.

The Policy will take effect on the date specified in the Policy. Coverage under the Policy will begin at 12:01 a.m. and end at 12:00 midnight in the time zone of the Enrolling Group's location. The Policy will remain in effect as long as the Policy Charges are paid when they are due, subject to termination of the Policy.

We are delivering the Policy in the State of Texas. The Policy is governed by ERISA unless the Enrolling Group is not an employee welfare benefit plan as defined by ERISA. To the extent that state law applies, the laws of the State of Texas are the laws that govern the Policy.

THE POLICY UNDER WHICH THIS CERTIFICATE IS ISSUED IS NOT A POLICY OF WORKERS' COMPENSATION INSURANCE. YOU SHOULD CONSULT YOUR EMPLOYER TO DETERMINE WHETHER YOUR EMPLOYER IS A SUBSCRIBER TO THE WORKERS' COMPENSATION SYSTEM.

Introduction to Your Certificate

We are pleased to provide you with this *Certificate*. This *Certificate* and the other Policy documents describe your Benefits, as well as your rights and responsibilities, under the Policy.

How to Use this Document

We encourage you to read your *Certificate* and any attached Riders and/or Amendments carefully.

We especially encourage you to review the Benefit limitations of this *Certificate* by reading the attached *Schedule of Benefits* along with *Section 1: Covered Health Services* and *Section 2: Exclusions and Limitations*. You should also carefully read *Section 8: General Legal Provisions* to better understand how this *Certificate* and your Benefits work. You should call us if you have questions about the limits of the coverage available to you.

Many of the sections of this *Certificate* are related to other sections of the document. You may not have all of the information you need by reading just one section. We also encourage you to keep your *Certificate* and *Schedule of Benefits* and any attachments in a safe place for your future reference.

If there is a conflict between this *Certificate* and any summaries provided to you by the Enrolling Group, this *Certificate* will control.

Please be aware that your Physician is not responsible for knowing or communicating your Benefits.

Information about Defined Terms

Because this *Certificate* is part of a legal document, we want to give you information about the document that will help you understand it. Certain capitalized words have special meanings. We have defined these words in *Section 9: Defined Terms*. You can refer to *Section 9: Defined Terms* as you read this document to have a clearer understanding of your *Certificate*.

When we use the words "we," "us," and "our" in this document, we are referring to UnitedHealthcare Insurance Company. When we use the words "you" and "your," we are referring to people who are Covered Persons, as that term is defined in *Section 9: Defined Terms*.

Don't Hesitate to Contact Us

Throughout the document you will find statements that encourage you to contact us for further information. Whenever you have a question or concern regarding your Benefits, please call us using the telephone number for *Customer Care* listed on your ID card. It will be our pleasure to assist you.

Your Responsibilities

Be Enrolled and Pay Required Contributions

Benefits are available to you only if you are enrolled for coverage under the Policy. Your enrollment options, and the corresponding dates that coverage begins, are listed in *Section 3: When Coverage Begins*. To be enrolled with us and receive Benefits, both of the following apply:

- Your enrollment must be in accordance with the Policy issued to your Enrolling Group, including the eligibility requirements.
- You must qualify as a Subscriber or his or her Dependent as those terms are defined in *Section 9: Defined Terms*.

Your Enrolling Group may require you to make certain payments to them, in order for you to remain enrolled under the Policy and receive Benefits. If you have questions about this, contact your Enrolling Group.

Be Aware this Benefit Plan Does Not Pay for All Health Services

Your right to Benefits is limited to Covered Health Services. The extent of this Benefit plan's payments for Covered Health Services and any obligation that you may have to pay for a portion of the cost of those Covered Health Services is set forth in the *Schedule of Benefits*.

Decide What Services You Should Receive

Care decisions are between you and your Physicians. We do not make decisions about the kind of care you should or should not receive.

Choose Your Physician

It is your responsibility to select the health care professionals who will deliver care to you. We arrange for Physicians and other health care professionals and facilities to participate in a Network. Our credentialing process confirms public information about the professionals' and facilities' licenses and other credentials, but does not assure the quality of their services. These professionals and facilities are independent practitioners and entities that are solely responsible for the care they deliver.

Pay Your Share

You must pay a Copayment and/or Coinsurance for most Covered Health Services. These payments are due at the time of service or when billed by the Physician, provider or facility. Copayment and Coinsurance amounts are listed in the *Schedule of Benefits*. You must also pay any amount that exceeds Eligible Expenses for non-Network expenses.

Pay the Cost of Excluded Services

You must pay the cost of all excluded services and items. Review *Section 2: Exclusions and Limitations* to become familiar with this Benefit plan's exclusions.

Show Your ID Card

You should show your identification (ID) card every time you request health services. If you do not show your ID card, the provider may fail to bill the correct entity for the services delivered, and any resulting delay may mean that you will be unable to collect any Benefits otherwise owed to you.

File Claims with Complete and Accurate Information

When you receive Covered Health Services from a non-Network provider, you are responsible for requesting payment from us or assigning Benefits directly to that provider. You must file the claim in a format that contains all of the information we require, as described in *Section 5: How to File a Claim*.

Use Your Prior Health Care Coverage

If you have prior coverage that, as required by state law, extends benefits for a particular condition or a disability, we will not pay Benefits for health services for that condition or disability until the prior coverage ends. We will pay Benefits as of the day your coverage begins under this Benefit plan for all other Covered Health Services that are not related to the condition or disability for which you have other coverage.

Our Responsibilities

Determine Benefits

We make administrative decisions regarding whether this Benefit plan will pay for any portion of the cost of a health care service you intend to receive or have received. Our decisions are for payment purposes only. We do not make decisions about the kind of care you should or should not receive. You and your providers must make those treatment decisions.

We have the discretion to do the following:

- Interpret Benefits and the other terms, limitations and exclusions set out in this *Certificate*, the *Schedule of Benefits*, and any Riders and/or Amendments.
- Make factual determinations relating to Benefits.

We may delegate this discretionary authority to other persons or entities that may provide administrative services for this Benefit plan, such as claims processing. The identity of the service providers and the nature of their services may be changed from time to time in our discretion. In order to receive Benefits, you must cooperate with those service providers.

Pay for Our Portion of the Cost of Covered Health Services

We pay Benefits for Covered Health Services as described in *Section 1: Covered Health Services* and in the *Schedule of Benefits*, unless the service is excluded in *Section 2: Exclusions and Limitations*. This means we only pay our portion of the cost of Covered Health Services. It also means that not all of the health care services you receive may be paid for (in full or in part) by this Benefit plan.

Pay Network Providers

It is the responsibility of Network Physicians and facilities to file for payment from us. When you receive Covered Health Services from Network providers, you do not have to submit a claim to us.

Pay for Covered Health Services Provided by Non-Network Providers

In accordance with any state prompt pay requirements, we will pay Benefits after we receive your request for payment that includes all required information. See *Section 5: How to File a Claim*.

Review and Determine Benefits in Accordance with our Reimbursement Policies

We develop our reimbursement policy guidelines, in our sole discretion, in accordance with one or more of the following methodologies:

- As indicated in the most recent edition of the *Current Procedural Terminology (CPT)*, a publication of the *American Medical Association*, and/or the *Centers for Medicare and Medicaid Services (CMS)*.
- As reported by generally recognized professionals or publications.
- As used for Medicare.
- As determined by medical staff and outside medical consultants pursuant to other appropriate sources or determinations that we accept.

Following evaluation and validation of certain provider billings (e.g., error, abuse and fraud reviews), our reimbursement policies are applied to provider billings. We share our reimbursement policies with Physicians and other providers in our Network through our provider website. Network Physicians and providers may not bill you for the difference between their contract rate (as may be modified by our reimbursement policies) and the billed charge. However, non-Network providers are not subject to this prohibition, and may bill you for any amounts we do not pay, including amounts that are denied because one of our reimbursement policies does not reimburse (in whole or in part) for the service billed. You may obtain copies of our reimbursement policies for yourself or to share with your non-Network Physician or provider by going to www.myuhc.com or by calling *Customer Care* at the telephone number on your ID card.

Offer Health Education Services to You

From time to time, we may provide you with access to information about additional services that are available to you, such as disease management programs, health education, and patient advocacy. It is solely your decision whether to participate in the programs, but we recommend that you discuss them with your Physician.

Certificate of Coverage Table of Contents

Section 1: Covered Health Services

Benefits for Covered Health Services

Benefits are available only if all of the following are true:

- Covered Health Services are received while the Policy is in effect.
- Covered Health Services are received prior to the date that any of the individual termination conditions listed in *Section 4: When Coverage Ends* occurs.
- The person who receives Covered Health Services is a Covered Person and meets all eligibility requirements specified in the Policy.

This section describes Covered Health Services for which Benefits are available. Please refer to the attached *Schedule of Benefits* for details about:

- The amount you must pay for these Covered Health Services (including any Annual Deductible, Copayment and/or Coinsurance).
- Any limit that applies to these Covered Health Services (including visit, day and dollar limits on services and/or any Maximum Policy Benefit).
- Any limit that applies to the amount you are required to pay in a year (Out-of-Pocket Maximum).
- Any responsibility you have for submitting a Request for pre-authorization of services to us or obtaining prior authorization. Refer to the *Schedule of Benefits* for Benefits that are subject to a Request for pre-authorization of services.

Please note that in listing services or examples, when we say "this includes," it is not our intent to limit the description to that specific list. When we do intend to limit a list of services or examples, we state specifically that the list "is limited to."

1. Ambulance Services

Emergency ambulance transportation by a licensed ambulance service to the nearest Hospital where Emergency Health Services can be performed.

Non-Emergency ambulance transportation by a licensed ambulance service (either ground or air ambulance, as we determine appropriate) between facilities when the transport is any of the following:

- From a non-Network Hospital to a Network Hospital.
- To a Hospital that provides a higher level of care that was not available at the original Hospital.
- To a more cost-effective acute care facility.
- From an acute facility to a sub-acute setting.

2. Clinical Trials

Routine patient care costs incurred during participation in a phase I, II, III or IV qualifying clinical trial for the prevention, detection or treatment of:

- Cancer.
- Cardiovascular disease (cardiac/stroke).

- Surgical musculoskeletal disorders of the spine, hip, and knees.
- Other life-threatening illnesses or conditions for which, as we determine, a clinical trial meets the qualifying clinical trial criteria stated below.

Benefits include the reasonable and necessary items and services used to diagnose and treat complications arising from participation in a qualifying clinical trial.

Benefits are available only when the Covered Person is clinically eligible for participation in the clinical trial as defined by the researcher. Benefits are not available for preventive clinical trials.

Routine patient care costs for clinical trials include:

- Covered Health Services for which Benefits are typically provided absent a clinical trial.
- Covered Health Services required solely for the provision of the Investigational item or service, the clinically appropriate monitoring of the effects of the item or service, or the prevention of complications.
- Covered Health Services needed for reasonable and necessary care arising from the provision of an Investigational item or service.

Routine costs for clinical trials do not include:

- The Experimental or Investigational Service or item. The only exceptions to this are:
  - Certain *Category B* devices.
  - Certain promising interventions for patients with terminal illnesses.
  - Other items and services that meet specified criteria in accordance with our medical policy guidelines.
- Items and services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient. Items and services associated with managing a clinical trial.
- Items and services that are clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.
- Items and services provided by the research sponsors free of charge for any person enrolled in the trial.
- Any item or service that is not a Covered Health Service, regardless of whether the item or service is required in connection with participation in a clinical trial.
- Any item or service that is specifically excluded from coverage under the Policy.

To be a qualifying clinical trial, a clinical trial must meet all of the following criteria:

- Be sponsored and provided by a cancer center that has been designated by the *National Cancer Institute (NCI)* as a *Clinical Cancer Center* or *Comprehensive Cancer Center* or be sponsored by any of the following:
  - The *U.S. Food and Drug Administration*.
  - The *National Institutes of Health (NIH),* including the *National Cancer Institute (NCI)*.
  - The *Centers for Disease Control and Prevention (CDC)*.
  - The *Agency for Healthcare Research and Quality (AHRQ)*.

  - The *Centers for Medicare and Medicaid Services (CMS)*.
  - The *Department of Defense (DOD)*.
  - The *U.S. Department of Veterans Administration (VA)*.
  - An institutional review board of an institution in Texas that has an agreement with the *Office for Human Research Protections* of the *U.S. Department of Health and Human Services*.

- The clinical trial must have a written protocol that describes a scientifically sound study and have been approved by all relevant institutional review boards (*IRBs*) before participants are enrolled in the trial. We may, at any time, request documentation about the trial to confirm that the clinical trial meets current standards for scientific merit and has the relevant *IRB* approvals.
- The subject or purpose of the trial must be the evaluation of an item or service that meets the definition of a Covered Health Service and is not otherwise excluded under the Policy.

Note: We are not required to reimburse the research institution conducting the clinical trial for the routine patient care provided through the research institution unless the research institution and each provider agree to accept reimbursement from us as payment in full for the routine patient care.

3. Congenital Heart Disease Surgeries

Congenital heart disease (CHD) surgeries which are ordered by a Physician. CHD surgical procedures include, but are not limited to, surgeries to treat conditions such as coarctation of the aorta, aortic stenosis, tetralogy of fallot, transposition of the great vessels, and hypoplastic left or right heart syndrome.

Benefits under this section include the facility charge and the charge for supplies and equipment. Benefits for Physician services are described under *Physician Fees for Surgical and Medical Services*.

Surgery may be performed as open or closed surgical procedures or may be performed through interventional cardiac catheterization.

We have specific guidelines regarding Benefits for CHD services. Contact us at the telephone number on your ID card for information about these guidelines.

4. Dental Services - Accident Only

Dental services when all of the following are true:

- Treatment is necessary because of accidental damage.
- Dental services are received from a Doctor of Dental Surgery or Doctor of Medical Dentistry.
- The dental damage is severe enough that initial contact with a Physician or dentist occurred within 72 hours of the accident. (You may request an extension of this time period provided that you do so within 60 days of the Injury and if extenuating circumstances exist due to the severity of the Injury.)

Please note that dental damage that occurs as a result of normal activities of daily living or extraordinary use of the teeth is not considered having occurred as an accident. Benefits are not available for repairs to teeth that are damaged as a result of such activities.

Dental services to repair damage caused by accidental Injury must conform to the following time-frames:

- Treatment is started within three months of the accident, unless extenuating circumstances exist (such as prolonged hospitalization or the presence of fixation wires from fracture care).
- Treatment must be completed within 12 months of the accident.

Benefits for treatment of accidental Injury are limited to the following:

- Emergency examination.
- Necessary diagnostic X-rays.
- Endodontic (root canal) treatment.
- Temporary splinting of teeth.
- Prefabricated post and core.
- Simple minimal restorative procedures (fillings).
- Extractions.
- Post-traumatic crowns if such are the only clinically acceptable treatment.
- Replacement of lost teeth due to the Injury by implant, dentures or bridges.

5. Diabetes Services

Diabetes equipment, diabetes supplies and diabetes self-management training programs when provided by or under the direction of a Doctor of Medicine, Doctor of Osteopathy or a Certified Diabetic Educator. Benefits also include new treatment modalities upon the approval of the FDA. All supplies, including medications and equipment for the control of diabetes shall be dispensed as written, including brand name products, unless substitution is approved by the Physician or practitioner who issues the written order.

Diabetes Self-Management and Training/Diabetic Eye Examinations/Foot Care

Diabetes self-management training includes training provided to a Covered Person in the care and management of that condition, including nutritional counseling and proper use of diabetes equipment and supplies. Benefits are also provided for additional training upon diagnosis of a significant change in medical condition that requires a change in the self-management regime and periodic continuing education training as warranted by the development of new techniques and treatment for diabetes.

Benefits under this section also include medical eye examinations (dilated retinal examinations) and preventive foot care for Covered Persons with diabetes.

Diabetic Self-Management Items

Diabetes equipment is limited to:

- Blood glucose monitors (including noninvasive monitors and monitors designed to be used by blind individuals).
- Insulin pumps, both external and implantable, and associated appurtenances which include insulin infusion devices, batteries, skin preparation items, adhesive supplies, infusion sets, insulin cartridges, durable and disposable devices to assist in the injection of insulin and other required disposable supplies. Benefits are included for repairs and necessary maintenance of insulin pumps that are not otherwise provided for under warranty or purchase agreement. Benefits are also included for rental fees for pumps during the repair and necessary maintenance of insulin pumps (neither of which shall exceed the purchase price of a similar replacement pump).
- Podiatric appliances including up to two pairs of therapeutic footwear per year, for the prevention of complications associated with diabetes.

Diabetes supplies are limited to:

- Test strips for blood glucose monitors.
- Visual reading and urine testing strips and tablets that test for glucose, ketones and protein.

- Lancets and lancet devices.
- Insulin and insulin analog preparations.
- Injection aids, including devices used to assist with insulin injection and needleless systems.
- Insulin syringes.
- Biohazard disposal containers.
- Glucagon emergency kits.
- Prescription and non-prescription oral agents for controlling blood sugar levels.

  Note: If an *Outpatient Prescription Drug Rider* is included under the Policy, Benefits for the prescription and non-prescription oral agents above will be provided under the *Outpatient Prescription Drug Rider*. Otherwise, the Benefits will be provided under this Benefit category of the *Certificate*.

6. Durable Medical Equipment

Durable Medical Equipment that meets each of the following criteria:

- Ordered or provided by a Physician for outpatient use primarily in a home setting.
- Used for medical purposes.
- Not consumable or disposable except as needed for the effective use of covered Durable Medical Equipment.
- Not of use to a person in the absence of a disease or disability.

Benefits under this section include Durable Medical Equipment provided to you by a Physician.

If more than one piece of Durable Medical Equipment can meet your functional needs, Benefits are available only for the equipment that meets the minimum specifications for your needs. If you rent or purchase a piece of Durable Medical Equipment that exceeds this guideline, you will be responsible for any cost difference between the piece you rent or purchase and the piece we have determined is the most cost-effective.

Examples of Durable Medical Equipment include:

- Equipment to assist mobility, such as a standard wheelchair.
- A standard Hospital-type bed.
- Oxygen and the rental of equipment to administer oxygen (including tubing, connectors and masks).
- Delivery pumps for tube feedings (including tubing and connectors).
- Braces, including necessary adjustments to shoes to accommodate braces. Braces that stabilize an injured body part and braces to treat curvature of the spine are considered Durable Medical Equipment and are a Covered Health Service. Braces that straighten or change the shape of a body part are orthotic devices, and are excluded from coverage. This exclusion does not apply to orthotic devices as described under *Prosthetic Devices* and *Orthotic Devices - Artificial Arms and Legs*.Dental braces are also excluded from coverage.
- Mechanical equipment necessary for the treatment of chronic or acute respiratory failure (except that air-conditioners, humidifiers, dehumidifiers, air purifiers and filters, and personal comfort items are excluded from coverage).

- Burn garments.
- Insulin pumps and all related necessary supplies as described under *Diabetes Services*.
- External cochlear devices and systems. Benefits for cochlear implantation are provided under the applicable medical/surgical Benefit categories in this *Certificate*.

Benefits under this section also include speech aid devices and tracheo-esophageal voice devices required for treatment of severe speech impediment or lack of speech directly attributed to Sickness or Injury. Benefits for the purchase of speech aid devices and tracheo-esophageal voice devices are available only after completing a required three-month rental period. Benefits are limited as stated in the *Schedule of Benefits*.

Benefits under this section do not include any device, appliance, pump, machine, stimulator, or monitor that is fully implanted into the body.

We will decide if the equipment should be purchased or rented.

Benefits are available for repairs and replacement, except that:

- Benefits for repair and replacement do not apply to damage due to misuse, malicious breakage or gross neglect.
- Benefits are not available to replace lost or stolen items.

7. Emergency Health Services - Outpatient

Services that are required to stabilize or initiate treatment in an Emergency. Emergency Health Services must be received on an outpatient basis at a Hospital, Alternate Facility or a Freestanding Emergency Medical Care Facility.

When Emergency Health Services are received in a Physician's office, the Benefits will be paid as described in *Physician's Office Services - Sickness and Injury* below.

Benefits under this section include the facility charge, supplies and all professional services required to stabilize your condition and/or initiate treatment as well as medical screening examination or other evaluation required by state or federal law that is necessary to determine whether an Emergency exists. This includes placement in an observation bed for the purpose of monitoring your condition (rather than being admitted to a Hospital for an Inpatient Stay).

8. Hearing Aids

Hearing aids required for the correction of a hearing impairment (a reduction in the ability to perceive sound which may range from slight to complete deafness). Hearing aids are electronic amplifying devices designed to bring sound more effectively into the ear. A hearing aid consists of a microphone, amplifier and receiver.

Benefits are available for a hearing aid that is purchased as a result of a written recommendation by a Physician. Benefits are provided for the hearing aid and for charges for associated fitting and testing.

Benefits under this section do not include bone anchored hearing aids. Bone anchored hearing aids are a Covered Health Service for which Benefits are available under the applicable medical/surgical Covered Health Services Benefit categories in this *Certificate*, only for Covered Persons who have either of the following:

- Craniofacial anomalies whose abnormal or absent ear canals preclude the use of a wearable hearing aid.

- Hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid.

9. Home Health Care

Services received from a Home Health Agency that are both of the following:

- Ordered by a Physician.
- Provided in your home by a registered nurse or licensed vocational nurse, or provided by either a home health aide or licensed practical nurse and supervised by a registered nurse.

Benefits are available only when the Home Health Agency services are provided on a part-time, Intermittent Care schedule and when skilled care is required.

Skilled care is skilled nursing, skilled teaching, and skilled rehabilitation services when all of the following are true:

- It must be delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome, and provide for the safety of the patient.
- It is ordered by a Physician.
- It is not delivered for the purpose of assisting with activities of daily living, including but not limited to dressing, feeding, bathing or transferring from a bed to a chair.
- It requires clinical training in order to be delivered safely and effectively.
- It is not Custodial Care.

We will determine if Benefits are available by reviewing both the skilled nature of the service and the need for Physician-directed medical management. A service will not be determined to be "skilled" simply because there is not an available caregiver.

Benefits include skilled nursing by a registered nurse or licensed vocational nurse; physical, occupational, speech or respiratory therapy; the service of a home health aide; and medical equipment and medical supplies other than drugs and medicines. A minimum of 60 visits will be covered in any calendar year or in any continuous period of 12 months for each person covered under the Policy. See the *Accessing Benefits* section of your *Schedule of Benefits* for additional information.

10. Hospice Care

Hospice care that is recommended by a Physician. Hospice care is an integrated program that provides comfort and support services for the terminally ill. Hospice care includes physical, psychological, social, spiritual and respite care for the terminally ill person and short-term grief counseling for immediate family members while the Covered Person is receiving hospice care. Benefits are available when hospice care is received from a licensed hospice agency.

Please contact us for more information regarding our guidelines for hospice care. You can contact us at the telephone number on your ID card.

11. Hospital - Inpatient Stay

Services and supplies provided during an Inpatient Stay in a Hospital. Benefits are available for:

- Supplies and non-Physician services received during the Inpatient Stay.
- Room and board in a Semi-private Room (a room with two or more beds).

- We provide Benefits, at a minimum, for an Inpatient Stay of at least 48 hours following a mastectomy and for 24 hours following a lymph node dissection for the treatment of breast cancer. The Covered Person and the treating Physician may determine that a shorter period of inpatient care is appropriate.
- Physician services for anesthesiologists, Emergency room Physicians, consulting Physicians, pathologists and radiologists. (Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services*.)

12. Lab, X-Ray and Diagnostics - Outpatient

Services for Sickness and Injury-related diagnostic purposes, received on an outpatient basis at a Hospital or Alternate Facility include, but are not limited to:

- Lab and radiology/X-ray.
- Mammography.

Benefits under this section include:

- The facility charge and the charge for supplies and equipment.
- Physician services for anesthesiologists, pathologists and radiologists. (Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services*.)

When these services are performed in a Physician's office, Benefits are described under *Physician's Office Services - Sickness and Injury*.

Lab, X-ray and diagnostic services for preventive care are described under *Preventive Care Services*.

13. Lab, X-Ray and Major Diagnostics - CT, PET Scans, MRI, MRA and Nuclear Medicine - Outpatient

Services for CT scans, PET scans, MRI, MRA, nuclear medicine, and major diagnostic services received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office.

Benefits under this section include:

- The facility charge and the charge for supplies and equipment.
- Physician services for anesthesiologists, pathologists and radiologists. (Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services*.)

14. Mental Health Services

Mental Health Services include those received on an inpatient or Intermediate Care basis in a Hospital or an Alternate Facility, and those received on an outpatient basis in a provider's office or at an Alternate Facility.

Mental Health Services under this Covered Health Services Benefit category include services for the following psychiatric illnesses (defined as "Serious Mental Illness" in *Section 9: Defined Terms*):

- Schizophrenia.
- Paranoid and other psychotic disorders.
- Bipolar disorders (hypomaniac, manic, depressive, and mixed).
- Major depressive disorders (single episode or recurrent).

- Schizo-affective disorders (bipolar or depressive).
- Obsessive-compulsive disorders.
- Depression in childhood and adolescence.

Benefits for Mental Health Services include:

- Mental health evaluations and assessment.
- Diagnosis.
- Treatment planning.
- Referral services.
- Medication management.
- Inpatient.
- Partial Hospitalization/Day Treatment.
- Intensive Outpatient Treatment.
- Services at a Residential Treatment Facility.
- Individual, family and group therapeutic services.
- Crisis intervention.

Benefits under this Benefit category include Mental Health Services for treatment of a Serious Mental Illness as required under State of Texas insurance law. Benefits are provided for alternative Mental Health Services in a Residential Treatment Center for Children and Adolescents, from a Crisis Stabilization Unit, or in a Mental Health Center or Psychiatric Day Treatment Facilities as required by State of Texas insurance law.

We will authorize the services and will determine the appropriate setting for the treatment. If an Inpatient Stay is required, it is covered on a Semi-private Room basis.

Referrals to a Mental Health Services provider are at our discretion and we are responsible for coordinating all of your care.

Mental Health Services must be authorized and overseen by us. Contact us regarding Benefits for Mental Health Services.

Special Mental Health Programs and Services

Special programs and services that are contracted under us may become available to you as a part of your Mental Health Services Benefit. The Mental Health Services Benefits and financial requirements assigned to these programs or services are based on the designation of the program or service to inpatient, Partial Hospitalization/Day Treatment, Intensive Outpatient Treatment, outpatient or a Transitional Care category of Benefit use. Special programs or services provide access to services that are beneficial for the treatment of your Mental Illness which may not otherwise be covered under the Policy. You must be referred to such programs through us and we are responsible for coordinating your care. Any decision to participate in such a program or service is at the discretion of the Covered Person and is not mandatory.

15. Neurobiological Disorders - Autism Spectrum Disorder Services

Psychiatric services for Autism Spectrum Disorders that are both of the following:

- Provided by or under the direction of an experienced psychiatrist and/or an experienced licensed psychiatric provider.
- Focused on treating maladaptive/stereotypic behaviors that are posing danger to self, others and property, and impairment in daily functioning.

This Benefit category describes only the psychiatric component of treatment for Autism Spectrum Disorders, for which Benefits are not subject to any age limit.

Medical treatment of Autism Spectrum Disorders for an Enrolled Dependent child from the date of diagnosis until the child completes nine years of age is a Covered Health Service for which Benefits are available as described under *Autism Spectrum Disorder Services* below in the sub-section entitled *Additional Benefits Required By Texas Law*. Medical treatment of Autism Spectrum Disorders for all other Covered Persons is a Covered Health Service for which Benefits are available under the applicable medical Covered Health Services Benefit categories in this *Certificate*.

Benefits include:

- Diagnostic evaluations and assessment.
- Treatment planning.
- Referral services.
- Medication management.
- Inpatient/24-hour supervisory care.
- Partial Hospitalization/Day Treatment.
- Intensive Outpatient Treatment.
- Services at a Residential Treatment Facility.
- Individual, family, therapeutic group, and provider-based case management services.
- Psychotherapy, consultation, and training session for parents and paraprofessional and resource support to family.
- Crisis intervention.
- Transitional Care.

Enhanced Autism Spectrum Disorder services that are focused on educational/behavioral intervention that are habilitative in nature and that are backed by credible research demonstrating that the services or supplies have a measurable and beneficial health outcome. Benefits are provided for intensive behavioral therapies (educational/behavioral services that are focused on primarily building skills and capabilities in communication, social interaction and learning such as *Applied Behavioral Analysis (ABA)*).

Autism Spectrum Disorder services must be authorized and overseen by us. Contact us regarding Benefits for *Neurobiological Disorders - Autism Spectrum Disorder Services*.

16. Ostomy Supplies

Benefits for ostomy supplies are limited to the following:

- Pouches, face plates and belts.
- Irrigation sleeves, bags and ostomy irrigation catheters.
- Skin barriers.

Benefits are not available for deodorants, filters, lubricants, tape, appliance cleaners, adhesive, adhesive remover, or other items not listed above.

17. Pharmaceutical Products - Outpatient

Pharmaceutical Products that are administered on an outpatient basis in a Hospital, Alternate Facility, Physician's office, or in a Covered Person's home.

Benefits under this section are provided only for Pharmaceutical Products which, due to their characteristics (as determined by us), must typically be administered or directly supervised by a qualified provider or licensed/certified health professional. Benefits under this section do not include medications that are typically available by prescription order or refill at a pharmacy.

Certain Pharmaceutical Products are subject to step therapy requirements. This means that in order to receive Benefits for such Pharmaceutical Products, you are required to use a different Pharmaceutical Product first. You may determine whether a particular Pharmaceutical Product is subject to step therapy requirements through the Internet at www.myuhc.com or by calling *Customer Care* at the telephone number on your ID card.

18. Physician Fees for Surgical and Medical Services

Physician fees for surgical procedures and other medical care received on an outpatient or inpatient basis in a Hospital, Skilled Nursing Facility, Inpatient Rehabilitation Facility or Alternate Facility, via telemedicine or telehealth, or for Physician house calls.

When these services are performed in a Physician's office, Benefits are described under *Physician's Office Services - Sickness and Injury*.

Face to face contact is not required between a health care provider and a patient, for services to be appropriately provided through telemedicine or telehealth. Services provided by telemedicine and telehealth are subject to the same terms and conditions of the Policy for any service provided face to face.

19. Physician's Office Services - Sickness and Injury

Services provided in a Physician's office for the diagnosis and treatment of a Sickness or Injury. Benefits are provided under this section regardless of whether the Physician's office is free-standing, located in a clinic or located in a Hospital.

Covered Health Services include medical education services that are provided in a Physician's office by appropriately licensed or registered healthcare professionals when both of the following are true:

- Education is required for a disease in which patient self-management is an important component of treatment.
- There exists a knowledge deficit regarding the disease which requires the intervention of a trained health professional.

Benefits under this section include allergy injections.

Covered Health Services for preventive care provided in a Physician's office are described under *Preventive Care Services*.

Benefits under this section include lab, radiology/X-ray or other diagnostic services performed in the Physician's office. Benefits under this section do not include CT scans, PET scans, MRI, MRA, nuclear medicine, and major diagnostic services.

20. Pregnancy - Maternity Services and Complications of Pregnancy

Benefits for Pregnancy include all maternity-related medical services for prenatal care, postnatal care, delivery, and any related complications.

Both before and during a Pregnancy, Benefits include the services of a genetic counselor when provided or referred by a Physician. These Benefits are available to all Covered Persons in the immediate family. Covered Health Services include related tests and treatment.

We also have special prenatal programs to help during Pregnancy. They are completely voluntary and there is no extra cost for participating in the program. To sign up, you should submit a Request for pre-authorization of services to us during the first trimester, but no later than one month prior to the anticipated childbirth. It is important that you submit a Request for pre-authorization of services to us regarding your Pregnancy. Your Request for pre-authorization of services will open the opportunity to become enrolled in prenatal programs designed to achieve the best outcomes for you and your baby.

We will pay Benefits for an Inpatient Stay of at least:

- 48 hours for the mother and newborn child following an uncomplicated normal vaginal delivery.
- 96 hours for the mother and newborn child following an uncomplicated cesarean section delivery.

If the mother agrees, the attending provider may discharge the mother and/or the newborn child earlier than these minimum time frames. If the discharge occurs earlier or if the delivery does not occur in a Hospital or other facility, Benefits are provided for post-delivery care provided by a Physician, a registered nurse or other appropriately licensed provider, either in the mother's home or at another location determined to be appropriate.

Post delivery care includes services provided in accordance with accepted maternal or neonatal physical assessment, parent education, breast or bottle feeding, education/training and performance of necessary and appropriate clinical tests.

Benefits for Complications of Pregnancy will be paid at the same level as Benefits for any other condition, Sickness or Injury and include all Covered Health Services required for the non-obstetrical treatment of a condition related to a Complication of Pregnancy during a Pregnancy or during the post-partum period.

Both before and during a Pregnancy, Benefits are provided for the services of a genetic counselor when provided or referred by a Physician. These Benefits are available to all Covered Persons in the immediate family. Covered Health Services include related tests and treatment.

We will pay Benefits for an Inpatient Stay of at least 96 hours for the mother and newborn child following a non-elective cesarean section delivery.

If the mother agrees, the attending provider may discharge the mother and/or the newborn child earlier than this minimum time frame.

21. Preventive Care Services

Services for preventive medical care provided on an outpatient basis at a Physician's office, an Alternate Facility or a Hospital. Examples of preventive medical care are:

Physician office services:

- Routine physical examinations.
- Well baby and well child care.
- Immunizations. Benefits for immunizations include, but are not limited to, any immunization required by law for an Enrolled Dependent child from birth through the date the child is six years

old. Specifically covered are immunizations against diphtheria, haemophilus influenza type B, hepatitis B, measles, mumps, pertussis, polio, rubella, tetanus and vercella.

- Hearing screening. A screening test for hearing loss is provided for a newborn Dependent from birth through the date the child is 30 days old. Necessary diagnostic follow-up care relating to the screening test is covered from birth through 24 months.
- Eye and ear examinations for children through age 17 to determine the need for vision and hearing correction.

Lab, X-ray or other preventive tests:

- Screening mammography.
- Colorectal Screening. Colorectal cancer screening for Covered Persons age 50 and over who are at normal risk of developing colon cancer as determined by a Physician. This screening includes:
  - A fecal occult blood test performed annually.
  - A stool DNA test performed annually.
  - A flexible sigmoidoscopy performed every five years.
  - A Computed Tomography (CT) colonography (also known as virtual colonscopy) performed every five years.
  - A colonoscopy performed every ten years.
- Cervical cancer screening. Benefits include an annual medically recognized diagnostic examination for the early detection of cervical cancer for female Covered Persons age 18 and older. Benefits include, at a minimum, a conventional pap smear for screening or a screening using liquid-based cytology methods, as approved by the *United States Food and Drug Administration (FDA)*, alone or in combination with a test approved by the *United States Food and Drug Administration (FDA)* for the detection of the human papillomavirus.
- Prostate cancer screening. Benefits include an annual diagnostic examination for the detection of prostate cancer, and a prostate-specific antigen test for each male who is:
  - At least 50 years old and asymptomatic, or
  - At least 40 years old with a family history of prostate cancer, or another prostate cancer risk factor.
- Noninvasive screening tests for atherosclerosis and abnormal artery structure and function for persons who are diabetic or who have a risk of developing coronary heart disease, based on an intermediate or higher score derived using the *Framingham Heart Study* coronary predictive algorithm, and who are either of the following:
  - A male Covered Person older than 45 years old but younger than 76 years old.
  - A female Covered Person older than 55 years old but younger than 76 years old.

  Benefits include:
  - Computed tomography (CT) scanning measuring coronary artery calcification.
  - Ultrasonography measuring carotid intima-media thickness and plaque.

  The screening tests must be performed by a laboratory certified by a national organization recognized by the *Texas Commissioner of Insurance*.

- Bone mineral density tests for osteoporosis detection and prevention. Benefits include a medically accepted bone mass measurement for the detection of low bone mass, when provided by or under the direction of a Physician. Benefits include testing for:
  - Postmenopausal women who are not receiving estrogen replacement therapy.
  - Individuals with vertebral abnormalities, primary hyperparathyroidism, or a history of bone fractures.
  - Individuals who are receiving long-term glucocorticoid therapy or being monitored to assess the response to or efficacy of an approved osteoporosis therapy.

22. Prosthetic Devices

External prosthetic devices that replace a limb or a body part, limited to:

- Artificial hands and feet. For information on prosthetic devices for artificial arms and legs, refer to the *Prosthetic Devices* and *Orthotic Devices - Artificial Arms and Legs* provision immediately below.
- Artificial face, eyes, ears and nose.
- Breast prosthesis as required by the *Women's Health and Cancer Rights Act of 1998*. Benefits include mastectomy bras and lymphedema stockings for the arm.

Benefits under this section are provided only for external prosthetic devices and do not include any device that is fully implanted into the body other than breast prostheses.

If more than one prosthetic device can meet your functional needs, Benefits are available only for the prosthetic device that meets the minimum specifications for your needs. If you purchase a prosthetic device that exceeds these minimum specifications, we will pay only the amount that we would have paid for the prosthetic that meets the minimum specifications, and you will be responsible for paying any difference in cost.

The prosthetic device must be ordered or provided by, or under the direction of a Physician.

Benefits are available for repairs and replacement, except that:

- There are no Benefits for repairs due to misuse, malicious damage or gross neglect.
- There are no Benefits for replacement due to misuse, malicious damage, gross neglect or for lost or stolen prosthetic devices.

23. Prosthetic Devices and Orthotic Devices - Artificial Arms and Legs

Prosthetic devices, orthotic devices and provider services related to the fitting and use of the prosthetic or orthotic devices. For the purposes of this provision:

- "Prosthetic device" means an artificial device designed to replace, wholly or partially, an arm or leg.
- "Orthotic device" means a custom-fitted or custom-fabricated medical device that is applied to a part of the human body (not limited to an arm or leg) to correct a deformity, improve function, or relieve symptoms of a disease.

If more than one prosthetic or orthotic device can meet your functional needs, Benefits are available only for the most appropriate model of prosthetic or orthotic device that meets your needs, as determined by your treating Physician. If you purchase a prosthetic or orthotic device that exceeds these specifications, we will pay only the amount that we would have paid for the prosthetic or orthotic device that meets the specifications, and you will be responsible for paying any difference in cost.

The prosthetic or orthotic device must be ordered or provided by, or under the direction of a Physician. The devices must not be solely for comfort or convenience.

Benefits are available for repairs and replacement, except that:

- There are no Benefits for repairs due to misuse, malicious damage or gross neglect.
- There are no Benefits for replacement due to misuse, malicious damage, gross neglect or for lost prosthetic or orthotic devices.

Covered Health Services under this section may be provided by a pharmacy with employees who are qualified under the Medicare system and applicable *Medicaid* regulations to service and bill for orthotic services.

24. Reconstructive Procedures

Reconstructive procedures when the primary purpose of the procedure is either to treat a medical condition or to improve or restore physiologic function. Reconstructive procedures include surgery or other procedures which are associated with an Injury, Sickness or Congenital Anomaly. The primary result of the procedure is not a changed or improved physical appearance.

Cosmetic Procedures are excluded from coverage. Procedures that correct an anatomical Congenital Anomaly without improving or restoring physiologic function are considered Cosmetic Procedures. The fact that a Covered Person may suffer psychological consequences or socially avoidant behavior as a result of an Injury, Sickness or Congenital Anomaly does not classify surgery (or other procedures done to relieve such consequences or behavior) as a reconstructive procedure.

For Covered Persons under the age of 18, Benefits are provided for the reconstructive procedures for craniofacial abnormalities to improve the function of or attempt to create the normal appearance of an abnormal structure caused by congenital defects, development of deformities, trauma, tumor, infections, or disease. (Benefits are not available for cranial banding, which is not a Covered Heath Service.)

Please note that Benefits for reconstructive procedures include breast reconstruction following a mastectomy, and reconstruction of the non-affected breast to achieve symmetry. Other services required by the *Women's Health and Cancer Rights Act of 1998*, including breast prostheses, treatment of physical complications including lymphedemas at all stages of mastectomy, mastectomy bras, lymphedema stockings for the arms and treatment of complications, are provided in the same manner and at the same level as those for any other Covered Health Service. You can contact us at the telephone number on your ID card for more information about Benefits for mastectomy-related services.

25. Rehabilitation Services - Outpatient Therapy and Manipulative Treatment

Short-term outpatient rehabilitation services, limited to:

- Physical therapy.
- Occupational therapy.
- Manipulative Treatment.
- Speech therapy.
- Pulmonary rehabilitation therapy.
- Cardiac rehabilitation therapy.
- Post-cochlear implant aural therapy.

Rehabilitation services must be performed by a Physician or by a licensed therapy provider. Benefits under this section include rehabilitation services provided in a Physician's office or on an outpatient basis at a Hospital or Alternate Facility.

Benefits can be denied or shortened for Covered Persons who are not progressing in goal-directed rehabilitation services or if rehabilitation goals have previously been met. Benefits can be denied or shortened for Covered Persons who are not progressing in goal-directed Manipulative Treatment or if treatment goals have previously been met. Benefits under this section are not available for maintenance/preventive Manipulative Treatment.

Benefits are available only for rehabilitation services that are expected to restore a Covered Person to the previous level of functioning (not to exceed activities of daily living). Benefits for rehabilitation services are not available for services that are expected to provide a higher level of functioning than the Covered Person previously possessed. For a physically disabled person, treatment goals may include maintenance of functioning or prevention of or slowing of further deterioration.

26. Scopic Procedures - Outpatient Diagnostic and Therapeutic

Diagnostic and therapeutic scopic procedures and related services received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office.

Diagnostic scopic procedures are those for visualization, biopsy and polyp removal. Examples of diagnostic scopic procedures include colonoscopy, sigmoidoscopy, and endoscopy.

Please note that Benefits under this section do not include surgical scopic procedures, which are for the purpose of performing surgery. Benefits for surgical scopic procedures are described under *Surgery - Outpatient*. Examples of surgical scopic procedures include arthroscopy, laparoscopy, bronchoscopy, hysteroscopy.

Benefits under this section include:

- The facility charge and the charge for supplies and equipment.
- Physician services for anesthesiologists, pathologists and radiologists. (Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services*.)

When these services are performed for preventive screening purposes, Benefits are described under *Preventive Care Services*.

27. Skilled Nursing Facility/Inpatient Rehabilitation Facility Services

Services and supplies provided during an Inpatient Stay in a Skilled Nursing Facility or Inpatient Rehabilitation Facility. Benefits are available for:

- Supplies and non-Physician services received during the Inpatient Stay.
- Room and board in a Semi-private Room (a room with two or more beds).
- Physician services for anesthesiologists, consulting Physicians, pathologists and radiologists. (Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services*.)

Please note that Benefits are available only if both of the following are true:

- If the initial confinement in a Skilled Nursing Facility or Inpatient Rehabilitation Facility was or will be a cost effective alternative to an Inpatient Stay in a Hospital.
- You will receive skilled care services that are not primarily Custodial Care.

Skilled care is skilled nursing, skilled teaching, and skilled rehabilitation services when all of the following are true:

- It must be delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome, and provide for the safety of the patient.
- It is ordered by a Physician.
- It is not delivered for the purpose of assisting with activities of daily living, including but not limited to dressing, feeding, bathing or transferring from a bed to a chair.
- It requires clinical training in order to be delivered safely and effectively.

We will determine if Benefits are available by reviewing both the skilled nature of the service and the need for Physician-directed medical management. A service will not be determined to be "skilled" simply because there is not an available caregiver.

Benefits can be denied or shortened for Covered Persons who are not progressing in goal-directed rehabilitation services or if discharge rehabilitation goals have previously been met.

28. Substance Use Disorder Services

Substance Use Disorder Services include those received on an inpatient or Intermediate Care basis in a Hospital or an Alternate Facility, and those received on an outpatient basis in a provider's office or at an Alternate Facility. Substance Use Disorder Services include services for Chemical Dependency as required by Texas state law and/or regulation.

Benefits for Substance Use Disorder Services include:

- Substance Use Disorder and Chemical Dependency evaluations and assessment.
- Diagnosis.
- Treatment planning.
- Detoxification (sub-acute/non-medical).
- Inpatient.
- Partial Hospitalization/Day Treatment.
- Intensive Outpatient Treatment.
- Services at a Residential Treatment Facility.
- Referral services.
- Medication management.
- Short-term individual, family and group therapeutic services (including intensive outpatient therapy).
- Crisis intervention.

Benefits under this section include Chemical Dependency services as required under State of Texas insurance law. Benefits include detoxification from abusive chemicals or substances that is limited to physical detoxification when necessary to protect your physical health and well-being. (Detoxification is the process of withdrawing a person from a specific psychoactive substance in a safe and effective manner.)

We will authorize the services, will determine the appropriate setting for the treatment. If an Inpatient Stay is required, it is covered on a Semi-private Room basis.

Referrals to a Substance Use Disorder Services provider are at our discretion and we are responsible for coordinating all of your care.

Substance Use Disorder Services must be authorized and overseen by us. Contact us regarding Benefits for *Substance Use Disorder Services*.

Special Substance Use Disorder Programs and Services

Special programs and services that are contracted under us may become available to you as a part of your Substance Use Disorder Services Benefit. The Substance Use Disorder Services Benefits and financial requirements assigned to these programs or services are based on the designation of the program or service to inpatient, Partial Hospitalization/Day Treatment, Intensive Outpatient Treatment, outpatient or a Transitional Care category of Benefit use. Special programs or services provide access to services that are beneficial for the treatment of your Substance Use Disorder which may not otherwise be covered under the Policy. You must be referred to such programs by us and we are responsible for coordinating your care. Any decision to participate in such a program or service is at the discretion of the Covered Person and is not mandatory.

29. Surgery - Outpatient

Surgery and related services received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office.

Benefits under this section include certain scopic procedures. Examples of surgical scopic procedures include arthroscopy, laparoscopy, bronchoscopy, hysteroscopy.

Benefits under this section include:

- The facility charge and the charge for supplies and equipment.
- Physician services for anesthesiologists, pathologists and radiologists. (Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services*.)

30. Temporomandibular Joint Services

Services for the evaluation and treatment of temporomandibular joint syndrome (TMJ) and associated muscles.

Diagnosis: Examination, radiographs and applicable imaging studies, and consultation.

Non-surgical treatment including clinical examinations, oral appliances (orthotic splints), arthrocentesis, and trigger-point injections.

Benefits are provided for surgical treatment if the following criteria are met:

- There is clearly demonstrated radiographic evidence of significant joint abnormality.
- Non-surgical treatment has failed to adequately resolve the symptoms.
- Pain or dysfunction is moderate or severe.

Benefits for surgical services include arthrocentesis, arthroscopy, arthroplasty, arthrotomy, open or closed reduction of dislocations. Benefits for surgical services also include *FDA*-approved TMJ implants only when all other treatment has failed.

31. Therapeutic Treatments - Outpatient

Therapeutic treatments received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office, including but not limited to dialysis (both hemodialysis and peritoneal dialysis), intravenous chemotherapy or other intravenous infusion therapy and radiation oncology.

Covered Health Services include medical education services that are provided on an outpatient basis at a Hospital or Alternate Facility by appropriately licensed or registered healthcare professionals when both of the following are true:

- Education is required for a disease in which patient self-management is an important component of treatment.
- There exists a knowledge deficit regarding the disease which requires the intervention of a trained health professional.

Benefits under this section include:

- The facility charge and the charge for related supplies and equipment.
- Physician services for anesthesiologists, pathologists and radiologists. Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services*.

32. Transplantation Services

Organ and tissue transplants when ordered by a Physician. Benefits are available for transplants when the transplant meets the definition of a Covered Health Service, and is not an Experimental or Investigational or Unproven Service.

Examples of transplants for which Benefits are available include bone marrow, heart, heart/lung, lung, kidney, kidney/pancreas, liver, liver/small bowel, pancreas, small bowel and cornea.

Donor costs that are directly related to organ removal are Covered Health Services for which Benefits are payable through the organ recipient's coverage under the Policy.

We have specific guidelines regarding Benefits for transplant services. Contact us at the telephone number on your ID card for information about these guidelines.

33. Urgent Care Center Services

Covered Health Services received at an Urgent Care Center. When services to treat urgent health care needs are provided in a Physician's office, Benefits are available as described under *Physician's Office Services - Sickness and Injury*.

34. Vision Examinations

Routine vision examinations, including refraction to detect vision impairment, received from a health care provider in the provider's office.

Please note that Benefits are not available for charges connected to the purchase or fitting of eyeglasses or contact lenses.

Benefits for eye examinations required for the diagnosis and treatment of a Sickness or Injury are provided under *Physician's Office Services - Sickness and Injury*.

Additional Benefits Required By Texas Law

35. Acquired Brain Injury

Benefits are provided for Covered Health Services that are determined by a Physician to be medically necessary as a result of and related to an acquired brain injury. Acquired brain injury is a neurological insult to the brain which is not hereditary, congenital or degenerative. The injury to the brain has occurred after birth and results in a change in neuronal activity, which results in an impairment of physical functioning, sensory processing, cognition, or psychosocial behavior. Benefits are provided for the Covered Health Services listed below when they are clinically proven, goal-oriented, efficacious, based on individualized treatment plans, required for and related to treatment of an acquired brain injury and provided by or under the direction of a Physician with the goal of returning the Covered Person to, or maintaining the Covered Person in, the most integrated living environment appropriate to the Covered Person.

Benefits also include reasonable expenses related to periodic reevaluation of the care of a Covered Person who has incurred an acquired brain injury, been unresponsive to treatment and becomes responsive to treatment at a later date. Factors considered in determining whether expenses are reasonable include all of the following:

- Cost.
- The time that has expired since the previous evaluation.
- Any difference in the expertise of the Physician or practitioner performing the evaluation.
- Changes in technology.
- Advances in medicine.

Covered Health Services necessary as a result of and related to an acquired brain injury include:

- Cognitive communication therapy - Services designed to address modalities of comprehension and expression, including understanding, reading, writing and verbal expression of information.
- Cognitive rehabilitation therapy - Services designed to address therapeutic cognitive activities based on an assessment and understanding of the individual's brain-behavioral deficits.
- Community reintegration services - Services that facilitate the continuum of care as an affected individual transitions into the community.
- Neurobehavioral testing - An evaluation of the history of neurological and psychiatric difficulty, current symptoms, current mental status, and premorbid history including the identification of problematic behavior and the relationship between behavior and the variables that control behavior. This may include interviews of the individual, family or others.
- Neurobehavioral treatment - Interventions that focus on behavior and the variables that control behavior.
- Neurocognitive rehabilitation - Services designed to assist cognitively impaired individuals to compensate for deficits in cognitive functioning by rebuilding cognitive skills and/or developing compensatory strategies and techniques.
- Neurocognitive therapy - Services designed to address neurological deficits in informational processing and to facilitate the development of higher level cognitive abilities.
- Neurofeedback therapy - Services that utilize operant conditioning learning procedure based on electroencephalography (EEG) parameters, and which are designed to result in improved mental performance and behavior, and stabilized mood.

- Neurophysiological testing - An evaluation of the functions of the nervous system.
- Neurophysiological treatment - Interventions that focus on the functions of the nervous system.
- Neuropsychological testing - The administering of a comprehensive battery of tests to evaluate neurocognitive, behavioral and emotional strengths and weaknesses and their relationship to normal and abnormal central nervous system functioning.
- Neuropsychological treatment - Interventions designed to improve or minimize deficits in behavioral and cognitive processes.
- Outpatient day treatment services - Structured services provided to address deficits in physiological, behavioral and/or cognitive functions. Such services may be delivered in settings that include transitional residential, community integration, or non-residential treatment settings.
- Post-acute care treatment services - Services provided after acute care confinement and/or treatment that are based on an assessment of the individual's physical, behavioral or cognitive functional deficits, which include a treatment goal of achieving functional changes by reinforcing, strengthening, or re-establishing previously learned patterns of behavior and/or establishing new patterns of cognitive activity or compensatory mechanisms.
- Post-acute transition services - Services that facilitate the continuum of care beyond the initial neurological insult through rehabilitation and community reintegration.
- Psychophysiological testing - An evaluation of the interrelationships between the nervous system and other bodily organs and behavior.
- Psychophysiological treatment - Interventions designed to alleviate or decrease abnormal physiological responses of the nervous system due to behavioral or emotional factors.
- Remediation - The process of restoring or improving a specific function.
- Treatment facilities - Treatment for an acquired brain injury may be provided at a facility at which the services listed above may be provided including a Hospital, acute or post-acute rehabilitation hospital and Assisted Living Facility. Benefits are not available for Custodial Care or maintenance care, Private Duty Nursing, domiciliary care, and personal care assistants as outlined in *U. Types of Care* in *Section 2: Exclusions and Limitations* of this *Certificate* regardless of where the services are provided.

36. Amino Acid-Based Elemental Formulas

Benefits are provided for amino acid-based elemental formulas, regardless of the formula delivery method, that are used for the diagnosis and treatment of:

- Immunoglobulin E and non-immunoglobulin E mediated allergies to multiple food proteins.
- Severe food protein-induced enterocolitis syndrome.
- Eosinophilic disorders, as evidenced by the results of a biopsy.
- Impaired absorption of nutrients caused by disorders affecting the absorptive surface, functional length and motility of the gastrointestinal tract.

Benefits will also be provided for any medically necessary services associated with the administration of the formula.

If an *Outpatient Prescription Drug Rider* is included under the Policy, Benefits for the amino acid-based elemental formulas will be provided under the *Outpatient Prescription Drug Rider*. Otherwise, the Benefits will be provided under this Benefit category of this *Certificate*.

For Benefits to be provided, the treating Physician must issue a written order stating that the amino acid-based elemental formula is medically necessary for the treatment of a Covered Person who is diagnosed with at least one of the diseases or disorders listed above.

37. Autism Spectrum Disorder Services

Benefits are provided for Covered Health Services for an Enrolled Dependent child who has been diagnosed with an Autism Spectrum Disorder from the date of diagnosis until the child completes nine years of age.

Benefits are provided for the generally recognized services listed below when prescribed by the Enrolled Dependent child's Primary Physician in the treatment plan recommended by that Physician. Benefits for psychiatric treatment for Autism Spectrum Disorder (including evaluation and assessment services, applied behavior analysis and behavior training and behavior management) are described above under *Neurobiological Disorders - Autism Spectrum Disorder Services*.

- Evaluation and assessment services.
- Speech therapy.
- Occupational therapy.
- Physical therapy.
- Medications or nutritional supplements used to address symptoms of Autism Spectrum Disorder.

The individual providing generally recognized services must be a health care practitioner who is licensed, certified, or registered by an appropriate agency of the State of Texas; whose professional credentials are recognized and accepted by an appropriate agency of the United States; or who is certified as a provider under the TRICARE military health system.

Please note that medical treatment of Autism Spectrum Disorders for all other Covered Persons is a Covered Health Service for which Benefits are available under the applicable medical Covered Health Services Benefit categories in this *Certificate*.

38. Developmental Delay Services

Rehabilitative and habilitative services that are determined to be necessary to, and provided in accordance with, an individualized family service plan issued by the *Interagency Council on Early Childhood Intervention*. Covered Health Services include:

- Occupational therapy evaluations and services.
- Physical therapy evaluations and services.
- Speech therapy evaluations and services.
- Dietary or nutritional evaluations.

39. Speech and Hearing Services

Services required (as determined by the Physician) as treatment for the loss or impairment of speech or hearing. Covered Health Services include speech and hearing therapy developmental, educational and learning speech and hearing therapy.

We also provide Benefits for hearing aids and costs associated with the fitting of hearing aids as described under Hearing Aids above.

Section 2: Exclusions and Limitations

How We Use Headings in this Section

To help you find specific exclusions more easily, we use headings (for example *A. Alternative Treatments* below). The headings group services, treatments, items, or supplies that fall into a similar category. Actual exclusions appear underneath headings. A heading does not create, define, modify, limit or expand an exclusion. All exclusions in this section apply to you.

We do not Pay Benefits for Exclusions

We will not pay Benefits for any of the services, treatments, items or supplies described in this section, even if either of the following is true:

- It is recommended or prescribed by a Physician.
- It is the only available treatment for your condition.

The services, treatments, items or supplies listed in this section are not Covered Health Services, except as may be specifically provided for in *Section 1: Covered Health Services* or through a Rider to the Policy.

Benefit Limitations

When Benefits are limited within any of the Covered Health Service Benefit categories described in *Section 1: Covered Health Services*, those limits are stated in the corresponding Covered Health Service Benefit category in the *Schedule of Benefits*. Limits may also apply to some Covered Health Services that fall under more than one Covered Health Service Benefit category. When this occurs, those limits are also stated in the *Schedule of Benefits* under the heading *Benefit Limits*. Please review all limits carefully, as we will not pay Benefits for any of the services, treatments, items or supplies that exceed these Benefit limits.

Please note that in listing services or examples, when we say "this includes," it is not our intent to limit the description to that specific list. When we do intend to limit a list of services or examples, we state specifically that the list "is limited to."

A. Alternative Treatments

1. Acupressure and acupuncture.
2. Aromatherapy.
3. Hypnotism.
4. Massage therapy.
5. Rolfing.
6. Art therapy, music therapy, dance therapy, horseback therapy and other forms of alternative treatment as defined by the *National Center for Complementary and Alternative Medicine (NCCAM)* of the *National Institutes of Health*. This exclusion does not apply to Manipulative Treatment and non-manipulative osteopathic care for which Benefits are provided as described in *Section 1: Covered Health Services*.

B. Dental

1. Dental care (which includes dental X-rays, supplies and appliances and all associated expenses, including hospitalizations and anesthesia).

   This exclusion does not apply to accident-related dental services for which Benefits are provided as described under *Dental Services - Accident Only* in *Section 1: Covered Health Services*.

   This exclusion does not apply to dental care (oral examination, X-rays, extractions and non-surgical elimination of oral infection) required for the direct treatment of a medical condition for which Benefits are available under the Policy, limited to:

   - Transplant preparation.
   - Prior to the initiation of immunosuppressive drugs.
   - The direct treatment of acute traumatic Injury, cancer or cleft palate.
   - Services required by a Covered Person who is unable to undergo dental treatment in an office setting or under local anesthesia because of a documented physical, mental or medical reason.

   Dental care that is required to treat the effects of a medical condition, but that is not necessary to directly treat the medical condition, is excluded. Examples include treatment of dental caries resulting from dry mouth after radiation treatment or as a result of medication.

   Endodontics, periodontal surgery and restorative treatment are excluded.

2. Preventive care, diagnosis, treatment of or related to the teeth, jawbones or gums. Examples include:

   - Extraction, restoration and replacement of teeth.
   - Medical or surgical treatments of dental conditions.
   - Services to improve dental clinical outcomes.

   This exclusion does not apply to accident-related dental services for which Benefits are provided as described under *Dental Services - Accident Only* in *Section 1: Covered Health Services*.

3. Dental implants, bone grafts, and other implant-related procedures. This exclusion does not apply to accident-related dental services for which Benefits are provided as described under *Dental Services - Accident Only* in *Section 1: Covered Health Services*.

4. Dental braces (orthodontics).

5. Treatment of congenitally missing, malpositioned, or supernumerary teeth, even if part of a Congenital Anomaly.

C. Devices, Appliances and Prosthetics

1. Devices used specifically as safety items or to affect performance in sports-related activities.

2. Orthotic appliances that straighten or re-shape a body part. Examples include foot orthotics, cranial banding and some types of braces, including over-the-counter orthotic braces. This exclusion does not apply to orthotic devices as described under *Prosthetic Devices and Orthotic Devices - Artificial Arms and Legs* in *Section 1: Covered Health Services*.

3. The following items are excluded, even if prescribed by a Physician:

   - Blood pressure cuff/monitor.

- Enuresis alarm.
- Home coagulation testing equipment.
- Non-wearable external defibrillator.
- Trusses.
- Ultrasonic nebulizers.
- Ventricular assist devices.

4. Devices and computers to assist in communication and speech except for speech generating devices and tracheo-esophageal voice devices for which Benefits are provided as described under *Durable Medical Equipment* in *Section 1: Covered Health Services*.
5. Oral appliances for snoring.
6. Repairs to prosthetic or orthotic devices due to misuse, malicious damage or gross neglect.
7. Replacement of prosthetic devices due to misuse, malicious damage or gross neglect or to replace lost items.

D. Drugs

1. Prescription drug products for outpatient use that are filled by a prescription order or refill. This exclusion does not apply to prescription and non-prescription oral agents for controlling blood sugar levels. **Note**: If an *Outpatient Prescription Drug Rider* is included under the Policy, Benefits for the prescription and non-prescription oral agents will be provided under the *Outpatient Prescription Drug Rider*. Otherwise, the Benefits will be provided under this Benefit category of the *Certificate*.
2. Self-injectable medications. This exclusion does not apply to medications which, due to their characteristics (as determined by us), must typically be administered or directly supervised by a qualified provider or licensed/certified health professional in an outpatient setting. This exclusion does not apply to self-injectable medications for which Benefits are provided as described under *Diabetes Services* in *Section 1: Covered Health Services*.
3. Non-injectable medications given in a Physician's office. This exclusion does not apply to non-injectable medications that are required in an Emergency and consumed in the Physician's office.
4. Over-the-counter drugs and treatments. This exclusion does not apply to over-the-counter drugs and treatments for which Benefits are provided as described under *Diabetes Services* in *Section 1: Covered Health Services*.
5. Growth hormone therapy.

E. Experimental or Investigational or Unproven Services

Experimental or Investigational and Unproven Services and all services related to Experimental or Investigational and Unproven Services are excluded. The fact that an Experimental or Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in Benefits if the procedure is considered to be Experimental or Investigational or Unproven in the treatment of that particular condition.

This exclusion does not apply to Covered Health Services provided during a clinical trial for which Benefits are provided as described under *Clinical Trials* in *Section 1: Covered Health Services*.

F. Foot Care

1. Routine foot care. Examples include the cutting or removal of corns and calluses. This exclusion does not apply to preventive foot care for Covered Persons with diabetes for which Benefits are provided as described under *Diabetes Services* in *Section 1: Covered Health Services*.
2. Nail trimming, cutting, or debriding.
3. Hygienic and preventive maintenance foot care. Examples include:
   - Cleaning and soaking the feet.
   - Applying skin creams in order to maintain skin tone.

   This exclusion does not apply to preventive foot care for Covered Persons who are at risk of neurological or vascular disease arising from diseases such as diabetes.
4. Treatment of flat feet.
5. Treatment of subluxation of the foot.
6. Shoes.
7. Shoe orthotics. This exclusion does not apply to podiatric appliances or therapeutic footwear as described under *Diabetes Services* or *Prosthetic Devices and Orthotic Devices - Artificial Arms and Legs* in *Section 1: Covered Health Services*.
8. Shoe inserts.
9. Arch supports.

G. Medical Supplies

1. Prescribed or non-prescribed medical supplies and disposable supplies. Examples include:
   - Elastic stockings.
   - Ace bandages.
   - Gauze and dressings.
   - Urinary catheters.

   This exclusion does not apply to:
   - Disposable supplies necessary for the effective use of Durable Medical Equipment for which Benefits are provided as described under *Durable Medical Equipment* in *Section 1: Covered Health Services*.
   - Diabetic supplies for which Benefits are provided as described under *Diabetes Services* in *Section 1: Covered Health Services*.
   - Ostomy supplies for which Benefits are provided as described under *Ostomy Supplies* in *Section 1: Covered Health Services*.
2. Tubings and masks except when used with Durable Medical Equipment as described under *Durable Medical Equipment* in *Section 1: Covered Health Services*.

H. Mental Health

1. Services performed in connection with conditions not classified in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.

2. Mental Health Services as treatments for V-code conditions as listed within the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.

3. Mental Health Services that extend beyond the period necessary for evaluation, diagnosis, the application of evidence-based treatments or crisis intervention to be effective.

4. Mental Health Services as treatment for a primary diagnosis of insomnia and other sleep disorders, sexual dysfunction disorders, feeding disorders, neurological disorders and other disorders with a known physical basis.

5. Treatments for the primary diagnoses of learning disabilities, conduct and impulse control disorders, personality disorders, paraphilias, and other Mental Illnesses that will not substantially improve beyond the current level of functioning, or that are not subject to favorable modification or management according to prevailing national standards of clinical practice, as reasonably determined by us.

6. Educational/behavioral services that are focused on primarily building skills and capabilities in communication, social interaction and learning.

7. Tuition for or services that are school-based for children and adolescents under the *Individuals with Disabilities Education Act*.

8. Learning, motor skills, and primary communication disorders as defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.

9. Mental retardation and Autism Spectrum Disorder as a primary diagnosis defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*. Benefits for the treatment of Autism Spectrum Disorders as a primary diagnosis are available under the *Neurobiological Disorders - Autism Spectrum Disorder Services* Benefit category rather than under the *Mental Health Services* Benefit category.

10. Treatment provided in connection with or to comply with involuntary commitments, police detentions and other similar arrangements, unless authorized by us.

11. Residential treatment services, except as specifically described as a Benefit under *Mental Health Services* in *Section 1: Covered Health Services*.

12. Services or supplies for the diagnosis or treatment of Mental Illness that, in our reasonable judgment, are any of the following:

    - Not consistent with generally accepted standards of medical practice for the treatment of such conditions.
    - Not consistent with services backed by credible research soundly demonstrating that the services or supplies will have a measurable and beneficial health outcome, and therefore considered experimental.
    - Typically do not result in outcomes demonstrably better than other available treatment alternatives that are less intensive or more cost effective.
    - Not consistent with our level of care guidelines or best practices as modified from time to time.
    - Not clinically appropriate in terms of type, frequency, extent, site and duration of treatment, and considered ineffective for the patient's Mental Illness, substance use disorder or condition based on generally accepted standards of medical practice and benchmarks.

    We may consult with professional clinical consultants, peer review committees or other appropriate sources for recommendations and information regarding whether a service or supply meets any of these criteria.

I. Neurobiological Disorders - Autism Spectrum Disorders

1. Services as treatments of sexual dysfunction and feeding disorders as listed in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.

2. Any treatments or other specialized services designed for Autism Spectrum Disorder that are not backed by credible research demonstrating that the services or supplies have a measurable and beneficial health outcome and therefore considered Experimental or Investigational or Unproven Services.

3. Tuition for or services that are school-based for children and adolescents under the *Individuals with Disabilities Education Act*.

4. Learning, motor skills and primary communication disorders as defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association* and which are not a part of an Autism Spectrum Disorder.

5. Treatments for the primary diagnoses of conduct and impulse control disorders, personality disorders, paraphilias, and other Mental Illnesses and Autism Spectrum Disorders that will not and/or have not substantially improve beyond the current level of functioning, or that are not subject to favorable modification or management according to prevailing national standards of clinical practice, as reasonably determined by us.

6. Treatment provided in connection with or to comply with involuntary commitments, police detentions and other similar arrangements, unless authorized by us.

7. Services or supplies for the diagnosis or treatment of Mental Illness that, in our reasonable judgment, are any of the following:

   - Not consistent with generally accepted standards of medical practice for the treatment of such conditions.
   - Not consistent with services backed by credible research soundly demonstrating that the services or supplies will have a measurable and beneficial health outcome, and therefore considered experimental.
   - Typically do not result in outcomes demonstrably better than other available treatment alternatives that are less intensive or more cost effective.
   - Not consistent with our level of care guidelines or best practices as modified from time to time.
   - Not clinically appropriate in terms of type, frequency, extent, site and duration of treatment, and considered ineffective in addressing the needs of the Covered Person's Autism Spectrum Disorder or condition based on generally accepted standards of medical practice and benchmarks.

   We may consult with professional clinical consultants, peer review committees or other appropriate sources for recommendations and information regarding whether a service or supply meets any of these criteria.

8. Services that are considered custodial care.

J. Nutrition

1. Individual and group nutritional counseling. This exclusion does not apply to medical nutritional education services that are provided by appropriately licensed or registered health care professionals when both of the following are true:

- Nutritional education is required for a disease in which patient self-management is an important component of treatment.
- There exists a knowledge deficit regarding the disease which requires the intervention of a trained health professional.

2. Enteral feedings, even if the sole source of nutrition. This exclusion does not apply to amino acid-based elemental formulas as described under *Amino Acid-Based Elemental Formulas* in *Section 1: Covered Health Services*.
3. Infant formula and donor breast milk. This exclusion does not apply to amino acid-based elemental formulas as described under *Amino Acid-Based Elemental Formulas* in *Section 1: Covered Health Services*.
4. Nutritional or cosmetic therapy using high dose or mega quantities of vitamins, minerals or elements, and other nutrition-based therapy. Examples include supplements, electrolytes, and foods of any kind (including high protein foods and low carbohydrate foods). This exclusion does not apply to:
   - Nutritional supplements for the treatment of Autism Spectrum Disorders, as described in *Section 1: Covered Health Services*, which meet the definition of a Covered Health Service.
   - Amino acid-based elemental formulas as described under *Amino Acid-Based Elemental Formulas* in *Section 1: Covered Health Services*.
   - Formulas for phenylketonuria (PKU) or other heritable diseases.

K. Personal Care, Comfort or Convenience

1. Television.
2. Telephone.
3. Beauty/barber service.
4. Guest service.
5. Supplies, equipment and similar incidental services and supplies for personal comfort. Examples include:
   - Air conditioners, air purifiers and filters, dehumidifiers.
   - Batteries and battery chargers.
   - Breast pumps.
   - Car seats.
   - Chairs, bath chairs, feeding chairs, toddler chairs, chair lifts, recliners.
   - Electric scooters.
   - Exercise equipment.
   - Home modifications such as elevators, handrails and ramps.
   - Hot tubs.
   - Humidifiers.
   - Jacuzzis.
   - Mattresses.

- Medical alert systems.
- Motorized beds.
- Music devices.
- Personal computers.
- Pillows.
- Power-operated vehicles.
- Radios.
- Saunas.
- Stair lifts and stair glides.
- Strollers.
- Safety equipment.
- Treadmills.
- Vehicle modifications such as van lifts.
- Video players.
- Whirlpools.

L. Physical Appearance

1. Cosmetic Procedures. See the definition in *Section 9: Defined Terms*. Examples include:
   - Pharmacological regimens, nutritional procedures or treatments.
   - Scar or tattoo removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures).
   - Skin abrasion procedures performed as a treatment for acne.
   - Liposuction or removal of fat deposits considered undesirable, including fat accumulation under the male breast and nipple.
   - Treatment for skin wrinkles or any treatment to improve the appearance of the skin.
   - Treatment for spider veins.
   - Hair removal or replacement by any means.
2. Replacement of an existing breast implant if the earlier breast implant was performed as a Cosmetic Procedure. Note: Replacement of an existing breast implant is considered reconstructive if the initial breast implant followed mastectomy. See *Reconstructive Procedures* in *Section 1: Covered Health Services*.
3. Treatment of benign gynecomastia (abnormal breast enlargement in males).
4. Physical conditioning programs such as athletic training, body-building, exercise, fitness, flexibility, and diversion or general motivation.
5. Weight loss programs whether or not they are under medical supervision. Weight loss programs for medical reasons are also excluded.
6. Wigs regardless of the reason for the hair loss.

M. Preexisting Conditions

1. Benefits for the treatment of a Preexisting Condition are excluded until the date you have had Continuous Creditable Coverage for 12 months.

   This exclusion does not apply to newborn children, newly adopted children or children placed for adoption. This exception for newborn, adopted children and children placed for adoption no longer applies after the end of the first 63-day period during which the child has not had Continuous Creditable Coverage.

N. Procedures and Treatments

1. Excision or elimination of hanging skin on any part of the body. Examples include plastic surgery procedures called abdominoplasty or abdominal panniculectomy, and brachioplasty.
2. Medical and surgical treatment of excessive sweating (hyperhidrosis).
3. Medical and surgical treatment for snoring, except when provided as a part of treatment for documented obstructive sleep apnea.
4. Rehabilitation services and Manipulative Treatment to improve general physical condition that are provided to reduce potential risk factors, where significant therapeutic improvement is not expected, including but not limited to routine, long-term or maintenance/preventive treatment.
5. Psychosurgery.
6. Sex transformation operations.
7. Physiological modalities and procedures that result in similar or redundant therapeutic effects when performed on the same body region during the same visit or office encounter.
8. Biofeedback. This exclusion does not apply when the service is rendered with the diagnosis of acquired brain injury.
9. Surgical and non-surgical treatment of obesity.
10. Stand-alone multi-disciplinary smoking cessation programs.
11. Breast reduction except as coverage is required by the *Women's Health and Cancer Right's Act of 1998* for which Benefits are described under *Reconstructive Procedures* in *Section 1: Covered Health Services*.

O. Providers

1. Services performed by a provider who is a family member by birth or marriage. Examples include a spouse, brother, sister, parent or child. This includes any service the provider may perform on himself or herself. This exclusion does not apply to dentists.
2. Services performed by a provider with your same legal residence.
3. Services provided at a free-standing or Hospital-based diagnostic facility without an order written by a Physician or other provider. Services which are self-directed to a free-standing or Hospital-based diagnostic facility. Services ordered by a Physician or other provider who is an employee or representative of a free-standing or Hospital-based diagnostic facility, when that Physician or other provider:

   - Has not been actively involved in your medical care prior to ordering the service, or
   - Is not actively involved in your medical care after the service is received.

   This exclusion does not apply to mammography.

P. Reproduction

1. Health services and associated expenses for infertility treatments, including assisted reproductive technology, regardless of the reason for the treatment. This exclusion does not apply to services required to treat or correct underlying causes of infertility.
2. Surrogate parenting, donor eggs, donor sperm and host uterus.
3. Storage and retrieval of all reproductive materials. Examples include eggs, sperm, testicular tissue and ovarian tissue.
4. The reversal of voluntary sterilization.

Q. Services Provided under another Plan

1. Health services for which other coverage is required by federal, state or local law to be purchased or provided through other arrangements. Examples include coverage required by workers' compensation, no-fault auto insurance, or similar legislation.

   If coverage under workers' compensation or similar legislation is optional for you because you could elect it, or could have it elected for you, Benefits will not be paid for any Injury, Sickness or Mental Illness that would have been covered under workers' compensation or similar legislation had that coverage been elected.
2. Health services for treatment of military service-related disabilities, when you are legally entitled to other coverage and facilities are reasonably available to you.
3. Health services while on active military duty.

R. Substance Use Disorders

1. Services performed in connection with conditions not classified in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.
2. Substance Use Disorder Services that extend beyond the period necessary for evaluation, diagnosis, the application of evidence-based treatments or crisis intervention to be effective.
3. Methadone treatment as maintenance, L.A.A.M. (1-Alpha-Acetyl-Methadol), Cyclazocine, or their equivalents.
4. Substance Use Disorder Services for the treatment of nicotine or caffeine use.
5. Treatment provided in connection with or to comply with involuntary commitments, police detentions and other similar arrangements, unless authorized by us .
6. Services or supplies for the diagnosis or treatment of alcoholism or substance use disorders that, in our reasonable judgment, are any of the following:
   - Not consistent with generally accepted standards of medical practice for the treatment of such conditions.
   - Not consistent with services backed by credible research soundly demonstrating that the services or supplies will have a measurable and beneficial health outcome, and therefore considered experimental.
   - Typically do not result in outcomes demonstrably better than other available treatment alternatives that are less intensive or more cost effective.
   - Not consistent with our level of care guidelines or best practices as modified from time to time.

- Not clinically appropriate in terms of type, frequency, extent, site and duration of treatment, and considered ineffective for the patient's Mental Illness, substance use disorder or condition based on generally accepted standards of medical practice and benchmarks.

We may consult with professional clinical consultants, peer review committees or other appropriate sources for recommendations and information regarding whether a service or supply meets any of these criteria.

S. Transplants

1. Health services for organ and tissue transplants, except those described under *Transplantation Services* in *Section 1: Covered Health Services*.
2. Health services connected with the removal of an organ or tissue from you for purposes of a transplant to another person. (Donor costs that are directly related to organ removal are payable for a transplant through the organ recipient's Benefits under the Policy.)
3. Health services for transplants involving permanent mechanical or animal organs.

T. Travel

1. Health services provided in a foreign country, unless required as Emergency Health Services.
2. Travel or transportation expenses, even though prescribed by a Physician. Some travel expenses related to Covered Health Services received from a Designated Facility or Designated Physician may be reimbursed at our discretion.

U. Types of Care

1. Multi-disciplinary pain management programs provided on an inpatient basis.
2. Custodial Care or maintenance care.
3. Domiciliary care.
4. Private Duty Nursing. This exclusion does not apply to private duty nursing as described in the Private Duty Nursing definition under *Section 9: Defined Terms*
5. Respite care. This exclusion does not apply to respite care that is part of an integrated hospice care program of services provided to a terminally ill person by a licensed hospice care agency for which Benefits are described under *Hospice Care* in *Section 1: Covered Health Services*.
6. Rest cures.
7. Services of personal care attendants.
8. Work hardening (individualized treatment programs designed to return a person to work or to prepare a person for specific work).

V. Vision and Hearing

1. Purchase cost and fitting charge for eye glasses and contact lenses.
2. Implantable lenses used only to correct a refractive error (such as *Intacs* corneal implants).
3. Eye exercise or vision therapy.
4. Surgery that is intended to allow you to see better without glasses or other vision correction. Examples include radial keratotomy, laser, and other refractive eye surgery.

5. Bone anchored hearing aids except when either of the following applies:

   - For Covered Persons with craniofacial anomalies whose abnormal or absent ear canals preclude the use of a wearable hearing aid.
   - For Covered Persons with hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid.

   More than one bone anchored hearing aid per Covered Person who meets the above coverage criteria during the entire period of time the Covered Person is enrolled under the Policy.

   Repairs and/or replacement for a bone anchored hearing aid for Covered Persons who meet the above coverage criteria, other than for malfunctions.

W. All Other Exclusions

1. Health services and supplies that do not meet the definition of a Covered Health Service - see the definition in *Section 9: Defined Terms*.
2. Physical, psychiatric or psychological exams, testing, vaccinations, immunizations or treatments that are otherwise covered under the Policy when:

   - Required solely for purposes of school, sports or camp, travel, career or employment, insurance, marriage or adoption.
   - Related to judicial or administrative proceedings or orders.
   - Conducted for purposes of medical research.
   - Required to obtain or maintain a license of any type.

3. Health services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country. This exclusion does not apply to Covered Persons who are civilians Injured or otherwise affected by war, any act of war, or terrorism in non-war zones.
4. Health services received after the date your coverage under the Policy ends. This applies to all health services, even if the health service is required to treat a medical condition that arose before the date your coverage under the Policy ended.
5. Health services for which you have no legal responsibility to pay, or for which a charge would not ordinarily be made in the absence of coverage under the Policy.
6. In the event a non-Network provider waives Copayments, Coinsurance and/or any deductible for a particular health service, no Benefits are provided for the health service for which the Copayments, Coinsurance and/or deductible are waived.
7. Charges in excess of Eligible Expenses or in excess of any specified limitation.
8. Long term (more than 30 days) storage. Examples include cryopreservation of tissue, blood and blood products.
9. Autopsy.
10. Foreign language and sign language services.

Section 3: When Coverage Begins

How to Enroll

Eligible Persons must complete an enrollment form. The Enrolling Group will give the necessary forms to you. The Enrolling Group will then submit the completed forms to us, along with any required Premium. We will not provide Benefits for health services that you receive before your effective date of coverage.

If You Are Hospitalized When Your Coverage Begins

If you are an inpatient in a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility on the day your coverage begins, we will pay Benefits for Covered Health Services that you receive on or after your first day of coverage related to that Inpatient Stay as long as you receive Covered Health Services in accordance with the terms of the Policy. These Benefits are subject to any prior carrier's obligations under state law or contract.

You should submit a Request for pre-authorization of services to us for your hospitalization within 48 hours of the day your coverage begins, or as soon as is reasonably possible. For Benefit plans that have a Network Benefit level, Network Benefits are available only if you receive Covered Health Services from Network providers.

If you are confined in a non-Network Hospital due to an Emergency, we may elect to transfer you to a Network Hospital as soon as it is medically appropriate to do so. If you choose to stay in the non-Network Hospital after the date we decide a transfer is medically appropriate, Network Benefits will not be available.

Transfers to a Network facility will not be considered until:

- A medical screening examination or other evaluation has been completed to determine if a medical Emergency condition exists and
- The necessary Emergency care services, including the treatment and stabilization of an Emergency medical condition have been rendered.

Who is Eligible for Coverage

The Enrolling Group determines who is eligible to enroll under the Policy and who qualifies as a Dependent.

Eligible Person

Eligible Person usually refers to an employee or member of the Enrolling Group who meets the eligibility rules. When an Eligible Person actually enrolls, we refer to that person as a Subscriber. For a complete definition of Eligible Person, Enrolling Group and Subscriber, see *Section 9: Defined Terms*.

If both spouses are Eligible Persons of the Enrolling Group, each may enroll as a Subscriber or be covered as an Enrolled Dependent of the other, but not both.

Dependent

Dependent generally refers to the Subscriber's spouse and children. When a Dependent actually enrolls, we refer to that person as an Enrolled Dependent. For a complete definition of Dependent and Enrolled Dependent, see *Section 9: Defined Terms*.

Dependents of an Eligible Person may not enroll unless the Eligible Person is also covered under the Policy.

If both parents of a Dependent child are enrolled as a Subscriber, only one parent may enroll the child as a Dependent.

When to Enroll and When Coverage Begins

Except as described below, Eligible Persons may not enroll themselves or their Dependents.

Initial Enrollment Period

When the Enrolling Group purchases coverage under the Policy from us, the Initial Enrollment Period is the first period of time when Eligible Persons can enroll themselves and their Dependents.

Coverage begins on the date identified in the Policy if we receive the completed enrollment form and any required Premium within 31 days of the date the Eligible Person becomes eligible to enroll.

Open Enrollment Period

The Enrolling Group determines the Open Enrollment Period. During the Open Enrollment Period, Eligible Persons can enroll themselves and their Dependents.

Coverage begins on the date identified by the Enrolling Group if we receive the completed enrollment form and any required Premium within 31 days of the date the Eligible Person becomes eligible to enroll.

New Eligible Persons

Coverage for a new Eligible Person and his or her Dependents begins on the date agreed to by the Enrolling Group if we receive the completed enrollment form and any required Premium within the Open Enrollment Period. The Open Enrollment period shall be a period at least 31 days in duration, available annually.

Adding New Dependents

Subscribers may enroll Dependents who join their family because of any of the following events:

- Birth.
- Legal adoption.
- Placement for adoption.
- The Subscriber is a party in suit seeking adoption.
- Marriage.
- Legal guardianship.
- Court or administrative order.
- Registering a Domestic Partner.

Coverage for the Dependent begins on the date of the event if we receive the completed enrollment form and any required Premium within 31 days of the event that makes the new Dependent eligible.

Coverage for a new Dependent child by birth or adoption begins on the date of the event and remains in effect for 31 days. To continue coverage beyond the initial 31-day period, the Subscriber must notify us of

the event and pay any required Premium within 31 days of the event. Benefits for Covered Health Services for congenital defects and birth abnormalities (including Congenital Anomalies) are available at the same level as those for any other Sickness or Injury.

Coverage for a Dependent child when required by a medical support order begins on the date of receipt of either the medical support order, or the notice of the medical support order, and remains in effect for 31 days. To continue coverage beyond the initial 31-day period, we must receive a completed enrollment form and payment of any required Premium within 31 days of receipt of the medical support order. The Subscriber, the custodial parent, a child support agency, or the Dependent child (if over age 18) may complete and sign the enrollment form on behalf of the Dependent child. If the Eligible Person is not already enrolled, he or she is also eligible to enroll if required by a medical support order to provide health care coverage to his or her Dependent child. The Eligible Person must provide proof, satisfactory to us, of the requirement to provide health care coverage.

Special Enrollment Period

An Eligible Person and/or Dependent may also be able to enroll during a special enrollment period. A special enrollment period is not available to an Eligible Person and his or her Dependents if coverage under the prior plan was terminated for cause, or because premiums were not paid on a timely basis.

An Eligible Person and/or Dependent does not need to elect COBRA continuation coverage to preserve special enrollment rights. Special enrollment is available to an Eligible Person and/or Dependent even if COBRA is not elected.

A special enrollment period applies to an Eligible Person and any Dependents when one of the following events occurs:

- Birth.
- Legal adoption.
- Placement for adoption.
- The Subscriber is a party in suit seeking adoption.
- Marriage.
- Court or administrative order.
- Registering a Domestic Partner.

A special enrollment period also applies for an Eligible Person and/or Dependent who did not enroll during the Initial Enrollment Period or Open Enrollment Period if the following are true:

- The Eligible Person previously declined coverage under the Policy, but the Eligible Person and/or Dependent becomes eligible for a premium assistance subsidy under *Medicaid* or *Children's Health Insurance Program (CHIP)*. Coverage will begin only if we receive the completed enrollment form and any required Premium within 60 days of the date of determination of subsidy eligibility.
- The Eligible Person and/or Dependent had existing health coverage under another plan at the time they had an opportunity to enroll during the Initial Enrollment Period or Open Enrollment Period; and
- Coverage under the prior plan ended because of any of the following:
    - Loss of eligibility (including, but not limited to, legal separation, divorce or death) as well as a child of a covered employee who has lost coverage under Chapter 62 Health and Safety Code, Child Health Plan for Certain Low-Income Children or Title XIX of the Social Security Act (42 U.S.C. §§1396, et seq., Grants to States for Medical Assistance Programs) other

than coverage consisting solely of benefits under Section 1928 of that Act (42 U.S.C. §1396, Program for Distribution of Pediatric Vaccines).

- The employer stopped paying the contributions. This is true even if the Eligible Person and/or Dependent continues to receive coverage under the prior plan and to pay the amounts previously paid by the employer.
- In the case of COBRA continuation coverage, the coverage ended.
- The Eligible Person and/or Dependent no longer lives or works in an HMO service area if no other benefit option is available.
- The plan no longer offers benefits to a class of individuals that include the Eligible Person and/or Dependent.
- An Eligible Person and/or Dependent incurs a claim that would exceed a lifetime limit on all benefits.
- The Eligible Person and/or Dependent loses eligibility under *Medicaid* or *Children's Health Insurance Program (CHIP)*. Coverage will begin only if we receive the completed enrollment form and any required Premium within 60 days of the date coverage ended.

When an event takes place (for example, a birth, marriage, determination of eligibility for state subsidy), coverage begins on the date of the event if we receive the completed enrollment form and any required Premium within 31 days of the event unless otherwise noted above. Coverage for a newborn or newly adopted Dependent child is effective even if we do not receive an enrollment form or the required Premium as described below.

For an Eligible Person and/or Dependent who did not enroll during the Initial Enrollment Period or Open Enrollment Period because they had existing health coverage under another plan, coverage begins on the day immediately following the day coverage under the prior plan ends. Except as otherwise noted above, coverage will begin only if we receive the completed enrollment form and any required Premium within 31 days of the date coverage under the prior plan ended.

Section 4: When Coverage Ends

General Information about When Coverage Ends

We may discontinue this Benefit plan and/or all similar benefit plans at any time for the reasons explained in the Policy, as permitted by law.

Your entitlement to Benefits automatically ends on the date that coverage ends, even if you are hospitalized or are otherwise receiving medical treatment on that date.

When your coverage ends, we will still pay claims for Covered Health Services that you received before the date on which your coverage ended. However, once your coverage ends, we will not pay claims for any health services received after that date (even if the medical condition that is being treated occurred before the date your coverage ended).

Unless otherwise stated, an Enrolled Dependent's coverage ends on the date the Subscriber's coverage ends.

Please note that for Covered Persons who are subject to the *Extended Coverage for Total Disability* provision later in this section, entitlement to Benefits ends as described in that section.

Events Ending Your Coverage

Coverage ends on the earliest of the dates specified below:

- **The Entire Policy Ends**

  Your coverage ends on the date the Policy ends. In the event the entire Policy ends, the Enrolling Group is responsible for notifying you that your coverage has ended.

- **You Are No Longer Eligible**

  For Texas residents, your coverage ends on the last day of the calendar month in which you are no longer eligible to be a Subscriber or Enrolled Dependent and we receive written notice from the Enrolling Group instructing us to end your coverage consistent with Texas regulatory requirements. For non-Texas residents, your coverage ends on the date we receive written notice from the Enrolling Group instructing us to end your coverage, or the date requested in the notice, if later. Please refer to *Section 9: Defined Terms* for complete definitions of the terms "Eligible Person," "Subscriber," "Dependent" and "Enrolled Dependent."

- **We Receive Notice to End Coverage**

  Your coverage ends on the last day of the calendar month in which we receive written notice from the Enrolling Group instructing us to end your coverage, or the date requested in the notice, if later. The Enrolling Group is responsible for providing written notice to us to end your coverage.

- **Subscriber Retires or Is Pensioned**

  For Texas residents, your coverage ends the last day of the calendar month in which the Subscriber is retired or receiving benefits under the Enrolling Group's pension or retirement plan and we receive written notice from the Enrolling Group instructing us to end your coverage consistent with Texas regulatory requirements. For non-Texas residents, your coverage ends on the date we receive written notice from the Enrolling Group instructing us to end your coverage, or the date requested in the notice, if later. The Enrolling Group is responsible for providing written notice to us to end your coverage.

This provision applies unless a specific coverage classification is designated for retired or pensioned persons in the Enrolling Group's application, and only if the Subscriber continues to meet any applicable eligibility requirements. The Enrolling Group can provide you with specific information about what coverage is available for retirees.

Other Events Ending Your Coverage

When any of the following happen, we will provide written notice to the Subscriber that coverage has ended on the date we identify in the notice:

- **Fraud, Misrepresentation or False Information**

  Fraud or misrepresentation of a material fact or the Subscriber knowingly and intentionally gave us false material information. Examples include false information relating to another person's eligibility or status as a Dependent.

  During the first two years the Policy is in effect, we have the right to demand that you pay back all Benefits we paid to you, or paid in your name, during the time you were incorrectly covered under the Policy. After the first two years, we can only demand that you pay back these Benefits if the written application contained a fraudulent misstatement. If your coverage ends for this reason, we will provide you 15 days prior written notice.

- **Material Violation**

  There was a material violation of the terms of the Policy, not related to health status.

Coverage for a Disabled Dependent Child

Coverage for an unmarried Enrolled Dependent child who is disabled will not end just because the child has reached a certain age. We will extend the coverage for that child beyond the limiting age if both of the following are true regarding the Enrolled Dependent child:

- Is not able to be self-supporting because of mental or physical handicap or disability.
- Depends mainly on the Subscriber for support.

Coverage will continue as long as the Enrolled Dependent is medically certified as disabled and dependent unless coverage is otherwise terminated in accordance with the terms of the Policy.

We will ask you to furnish us with proof of the medical certification of disability within 31 days of the date coverage would otherwise have ended because the child reached a certain age. Before we agree to this extension of coverage for the child, we may require that a Physician chosen by us examine the child. We will pay for that examination.

We may continue to ask you for proof that the child continues to be disabled and dependent. Such proof might include medical examinations at our expense. However, we will not ask for this information more than once a year.

If you do not provide proof of the child's disability and dependency within 31 days of our request as described above, coverage for that child will end.

Extended Coverage for Total Disability

Coverage for a Covered Person who is Totally Disabled on the date the entire Policy is terminated will not end automatically. We will temporarily extend the coverage, only for treatment of the condition causing the Total Disability. Benefits will be paid until the earlier of any of the following:

- The Total Disability ends.

- Three months from the date coverage would have ended when the entire Policy was terminated.
- The date the Covered Person obtains coverage under another policy that does not exclude treatment of the condition causing the Total Disability.
- The date maximum Benefits under the Policy have been provided.

Continuation of Coverage

If your coverage ends under the Policy, you may be entitled to elect continuation coverage (coverage that continues on in some form) in accordance with federal or state law.

Continuation coverage under COBRA (the federal Consolidated Omnibus Budget Reconciliation Act) is available only to Enrolling Groups that are subject to the terms of COBRA. You can contact your plan administrator to determine if your Enrolling Group is subject to the provisions of COBRA.

If you selected continuation coverage under a prior plan which was then replaced by coverage under the Policy, continuation coverage will end as scheduled under the prior plan or in accordance with federal or state law, whichever is earlier.

We are not the Enrolling Group's designated "plan administrator" as that term is used in federal law, and we do not assume any responsibilities of a "plan administrator" according to federal law.

We are not obligated to provide continuation coverage to you if the Enrolling Group or its plan administrator fails to perform its responsibilities under federal law. Examples of the responsibilities of the Enrolling Group or its plan administrator are:

- Notifying you in a timely manner of the right to elect continuation coverage.
- Notifying us in a timely manner of your election of continuation coverage.

Continuation of Coverage Under State Law

You may elect state continuation as described under the State Continuation Coverage provisions below.

Qualifying Events for State Continuation Coverage Due to Reasons Other than Severance of the Family Relationship

A Covered Person whose coverage terminates due to any reason except involuntary termination for cause, and who has been continuously covered under the Policy (and under any group contract providing similar services and benefits that it replaced) for at least three consecutive months immediately prior to termination, is entitled to continue coverage under state law. A person whose coverage terminates due to severance of the family relationship may either continue coverage as described immediately below, or if he or she meets the requirements described in *Qualifying Events for State Continuation Coverage Due to Severance of the Family Relationship*, may continue coverage as described in that provision.

Notification Requirements, Election Period and Premium Payment for State Continuation Coverage Due to Reasons Other than Severance of the Family Relationship

The Covered Person must provide a written request for continuation coverage to the Enrolling Group's designated Plan Administrator within 60 days after the later of these dates:

- The date group coverage would otherwise terminate.
- The date the Covered Person is given notice of the right to elect continuation.

The Covered Person must pay the initial Premium for the continuation coverage to the Enrolling Group's designated Plan Administrator within 45 days after the date of the initial election of coverage continuation. Following the payment of the initial Premium, the Covered Person must pay the monthly Premium for the coverage continuation to the designated Plan Administrator each month. Payment of the monthly continuation Premium will be considered timely if made on or before the 30th day after the date on which the payment is due.

Terminating Events for State Continuation Coverage Due to Reasons Other than Severance of the Family Relationship

State Continuation coverage due to reasons other than severance of the family relationship will end on the earliest of the following dates:

- Nine months from the date state continuation coverage was elected, if the Covered Person is not eligible for continuation coverage under Federal law (*COBRA*).
- Six months from the date state continuation coverage was elected, if the state continuation coverage followed continuation coverage under Federal law (*COBRA*).
- The date coverage ends for failure to make timely payment of the Premium.
- The date coverage ends because you violate a material condition of the Policy.
- The date the Covered Person is eligible for or covered under Medicare.
- The date the entire Policy ends.

Qualifying Events for State Continuation Coverage Due to Severance of the Family Relationship

If both of the following are true, a Covered Person whose coverage terminates may elect state continuation coverage under the Policy:

- The Covered Person has been covered under the Policy for at least one year, or is an infant under one year of age.
- The Covered Person's coverage under the Policy was terminated for one of the reasons set forth below:
  - Termination of the Subscriber from employment with the Enrolling Group.
  - Death of the Subscriber.
  - Divorce of the Subscriber.
  - Retirement of the Subscriber.

Notification Requirements, Election Period and Premium Payment for State Continuation Coverage Due to Severance of the Family Relationship

A Covered Person must provide written notice to the Enrolling Group within 15 days of any severance of the family relationship that might qualify for the continuation as described in *Qualifying Events for State Continuation Coverage Due to Severance of the Family Relationship*. Upon receipt of such notice, or upon receipt of notice of the Subscriber's death or retirement, the Enrolling Group shall immediately give written notice of the right to state continuation to each affected Enrolled Dependent. Within 60 days of

severance of the family relationship or the Subscriber's death or retirement, the Enrolled Dependent must give written notice to the Enrolling Group of his or her intent to elect state continuation. Coverage under the Policy remains in effect during the 60-day election period, provided the required Premium is paid. The Covered Person must pay the monthly Premium for the coverage continuation to the designated Plan Administrator each month. Payment of the monthly continuation Premium will be considered timely if made on or before the 30th day after the date on which the payment is due.

Termination Events for State Continuation Coverage Due to Severance of the Family Relationship

State continuation coverage due to severance of the family relationship will end on the earliest of the following dates:

- Three years from the date that the family relationship was severed or the date of the Subscriber's death or retirement.
- The date the Covered Person fails to make timely payment of the Premium.
- The date the Covered Person becomes eligible for substantially similar coverage under another health insurance policy, hospital or medical service subscriber contract, medical practice or other prepayment plan, or by any other plan or program.

Texas Health Insurance Risk Pool

We shall notify the Covered Person, not less than 30 days before the end of the six-month period or nine-month period, whichever is applicable as specified above, from the date the Covered Person elects continuation coverage under state law, that he or she may be eligible for coverage under the Texas Health Insurance Risk Pool. For additional information concerning eligibility, coverages, costs, limitations, exclusions, and termination provisions, call or write Texas Health Insurance Risk Pool, P.O. Box 6089, Abilene, TX, 79608-6089, 1-888-398-3927. Hearing and speech impaired users may call 1-800-735-2989.

Section 5: How to File a Claim

If You Receive Covered Health Services from a Network Provider

We pay Network providers directly for your Covered Health Services. If a Network provider bills you for any Covered Health Service, contact us. However, you are responsible for meeting any applicable Annual Deductible and for paying any required Copayments and Coinsurance to a Network provider at the time of service, or when you receive a bill from the provider.

If You Receive Covered Health Services from a Non-Network Provider

When you receive Covered Health Services from a non-Network provider, you are responsible for requesting payment from us. You must file the claim in a format that contains all of the information we require, as described below.

You should submit a request for payment of Benefits within 90 days after the date of service. If you don't provide this information to us within 15 months of the date of service, Benefits for that health service will be denied or reduced, in our discretion. This time limit does not apply if you are legally incapacitated. If your claim relates to an Inpatient Stay, the date of service is the date your Inpatient Stay ends.

Required Information

When you request payment of Benefits from us, you must provide us with all of the following information:

- The Subscriber's name and address.
- The patient's name and age.
- The number stated on your ID card.
- The name and address of the provider of the service(s).
- The name and address of any ordering Physician.
- A diagnosis from the Physician.
- An itemized bill from your provider that includes the Current Procedural Terminology (CPT) codes or a description of each charge.
- The date the Injury or Sickness began.
- A statement indicating either that you are, or you are not, enrolled for coverage under any other health insurance plan or program. If you are enrolled for other coverage you must include the name of the other carrier(s).

The above information should be filed with us at the address on your ID card.

Payment of Benefits

If a Subscriber provides written authorization to allow this, all or a portion of any Eligible Expenses due to a provider may be paid directly to the provider instead of being paid to the Subscriber. But we will not reimburse third parties that have purchased or been assigned benefits by Physicians or other providers.

Benefits will be paid to you unless either of the following is true:

- The provider notifies us that your signature is on file, assigning benefits directly to that provider.

- You make a written request at the time you submit your claim.

Section 6: Questions, Complaints and Appeals

To resolve a question, complaint, or appeal, just follow these steps:

What to Do if You Have a Question

Contact *Customer Care* at the telephone number shown on your ID card. *Customer Care* representatives are available to take your call during regular business hours, Monday through Friday.

What to Do if You Have a Complaint

Contact *Customer Care* at the telephone number shown on your ID card. *Customer Care* representatives are available to take your call during regular business hours, Monday through Friday.

If you would rather send your complaint to us in writing, the *Customer Care* representative can provide you with the appropriate address.

If the *Customer Care* representative cannot resolve the issue to your satisfaction over the telephone, he/she can help you prepare and submit an oral or written complaint.

We shall promptly investigate each complaint. The total time for acknowledgement, investigation and resolution of the complaint shall not exceed 30 calendar days after we receive the written complaint or the one-page complaint form.

Complaints concerning presently occurring Emergencies or denials of continued stays for hospitalization shall be investigated and resolved in accordance with the medical immediacy, and shall not exceed one business day from receipt of the complaint.

We shall not engage in any retaliatory action against any Covered Person. We shall not retaliate for any reason including, for example, cancellation of coverage or refusal to renew coverage because the Covered Person or person acting on behalf of the Covered Person has filed a complaint against the Policy or has appealed a decision.

How to Request an Appeal

If you receive a denial you can appeal. If your appeal relates to a non-clinical denial, refer to *How to Appeal a Non-clinical Benefit Determination* below.

All requests for an appeal should include:

- The patient's name and the identification number from the ID card.
- The date(s) of medical service(s).
- The provider's name.
- The reason you believe the claim should be paid.
- Any documentation or other written information to support your request for claim payment.

Please note that our decision is based only on whether or not Benefits are available under the Policy for the proposed treatment or procedure. The decision for you to receive services is between you and your Physician.

Request for Pre-authorization of Services

Request for pre-authorization of services is a notification to us of proposed services that will result in one of the following:

- A Pre-authorization;
- An Adverse Determination; or
- When there are no clinical issues for us to determine, a confirmation of receipt of your request.

If you receive an Adverse Determination, as described above, in response to your Request for pre-authorization of services, you may appeal the decision. Please refer to *How to Appeal an Adverse Determination* below. If you receive a pre-service Non-clinical Benefit Determination from us in response to our Request for pre-authorization of services, you may appeal our decision. Please refer to *How to Appeal a Non-clinical Benefit Determination* below.

For procedures associated with urgent Requests for pre-authorization of services, see *Urgent Appeals that Require Immediate Action* below.

Appeal Process

A qualified individual who was not involved in the decision being appealed will be appointed to decide the appeal.

How to Appeal an Adverse Determination

If you receive an Adverse Determination in response to a claim or a Request for pre-authorization of services, you, a person acting on your behalf, or your Physician or health care provider can contact us orally or in writing to formally request a clinical appeal.

Your request for an Adverse Determination appeal should include:

- The patient's name and the identification number from the ID card.
- The date(s) of medical service(s).
- The provider's name.
- The reason you believe the claim should be paid.
- Any documentation or other written information to support your request for claim payment.

Upon receipt of your appeal we will, within five working days, send you a letter acknowledging receipt of your appeal and provide you with a description of the Adverse Determination appeal process and a list of documents necessary to process your appeal.

Our review will be done in consultation with a health care professional with appropriate expertise in the field, who was not involved in the prior determination. We may consult with, or seek the participation of, medical experts as part of the appeal resolution process. You consent to this referral and the sharing of pertinent medical claim information. Upon request and free of charge, you have the right to reasonable access to and copies of all documents, records and other information relevant to your claim for Benefits.

Retrospective Review

If the Adverse Determination relates to a retrospective review, you will receive notice no later than 30 days after we receive your claim. We may extend this period for up to an additional 15 days if we determine an extension is necessary due to matters beyond our control. If an extension is needed, you will be notified within 30 days after we receive your claim. If the extension is necessary because we have

not received information from you or your provider, we will specifically describe the information needed and allow 45 days for the information to be submitted. We will make a decision within 30 days of the date of the extension notice until the earlier of the date you or your provider respond to the request for additional information or the date the information was to be submitted.

Denied Appeals Specialty Provider Review

If we uphold the clinical appeal, your provider may, within 10 working days of the appeal denial, request a review by a specialty provider by submitting a written request showing good cause for the additional review.

Denied Appeals - Independent Review Organization

If all of the following apply, you may request a review of a clinical benefit determination or an Adverse Determination by an *Independent Review Organization*:

- Your complaint relates to a clinical benefit determination or an Adverse Determination.
- The clinical benefit determination or Adverse Determination is upheld.
- You have exhausted the clinical appeal procedure as described above.

If the determination is to uphold the Adverse Determination, the written notice will include the clinical basis for the determination, the specialty of the Physician making the decision, and your right to appeal the decision.

If a complaint relates to a life-threatening condition, you may request an immediate review by an *Independent Review Organization* without exhausting the above described procedures.

We will pay for the costs relating to this review and will comply with the decision. You may request a review by an *Independent Review Organization* without exhausting the appeal procedure if the Adverse Determination relates to a life-threatening condition.

Urgent Appeals that Require Immediate Action

Your appeal may require immediate action if a delay in treatment could significantly increase the risk to your health, or the ability to regain maximum function, or cause severe pain. In these urgent situations:

- The appeal does not need to be submitted in writing. You or your Physician should call us as soon as possible.
- We will notify you of the decision by the end of the next business day following receipt of your request for review of the determination, taking into account the seriousness of your condition.
- If we need more information from your Physician to make a decision, we will notify you of the decision by the end of the next business day following receipt of the required information.
- The appeal process for urgent situations does not apply to prescheduled treatments, therapies or surgeries.

If you are not satisfied with our decision, you have the right to take your complaint to the *Texas Department of Insurance*.

How to Appeal a Non-clinical Benefit Determination

If you receive a benefit denial in response to a Request for pre-authorization of services or as a result of a post service claim determination, you, a person acting on your behalf, or your Physician or health care provider can contact us orally or in writing to formally request an appeal.

Your request for appeal should include:

- The patient's name and the identification number from the ID card.
- The date(s) of medical service(s).
- The provider's name.
- The reason you believe the claim should be paid.
- Any documentation or other written information to support your request for claim payment.

Non-clinical Benefit Determination is a determination made by us that proposed or delivered services are or are not covered services according to the terms of the insurance policy without reference to the medical necessity or appropriateness of the services. A Non-clinical Benefit Determination that services are not covered is not an Adverse Determination.

For appeals of Non-clinical Benefit Determinations and post service claims as identified above, the first level appeal will be conducted and you will be notified of the decision within 30 days from receipt of a request for appeal of a denied claim. If you are not satisfied with the first level appeal decision, you have the right to request a second level appeal. The second level appeal will be conducted and you will be notified of the decision within 30 days from receipt of a request for review of the first level appeal decision.

Section 7: Coordination of Benefits

Benefits When You Have Coverage under More than One Plan

This section describes how Benefits under the Policy will be coordinated with those of any other plan that provides benefits to you. The language in this section is from model laws drafted by the National Association of Insurance Commissioners (NAIC) and represents standard industry practice for coordinating benefits.

When Coordination of Benefits Applies

This coordination of benefits (COB) provision applies when a person has health care coverage under more than one Plan. Plan is defined below.

The order of benefit determination rules below govern the order in which each Plan will pay a claim for benefits. The Plan that pays first is called the Primary Plan. The Primary Plan must pay benefits in accordance with its policy terms without regard to the possibility that another Plan may cover some expenses. The Plan that pays after the Primary Plan is the Secondary Plan. The Secondary Plan may reduce the benefits it pays so that payments from all Plans do not exceed 100% of the total Allowable Expense.

Definitions

For purposes of this section, terms are defined as follows:

A. A Plan is any of the following that provides benefits or services for medical, pharmacy or dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts.

   1. Plan includes: group insurance contracts, health maintenance organization (HMO) contracts, closed panel plans or other forms of group or group-type coverage (whether insured or uninsured); medical care components of long-term care contracts, such as skilled nursing care; and Medicare or any other federal governmental plan, as permitted by law.

   2. Plan does not include: hospital indemnity coverage insurance or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; limited benefit health coverage, as defined by state law; school accident type coverage; benefits for non-medical components of long-term care policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law.

   Each contract for coverage under 1. or 2. above is a separate Plan. If a Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate Plan.

B. This Plan means, in a COB provision, the part of the contract providing the health care benefits to which the COB provision applies and which may be reduced because of the benefits of other plans. Any other part of the contract providing health care benefits is separate from This Plan. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.

C. The order of benefit determination rules determine whether This Plan is a Primary Plan or Secondary Plan when the person has health care coverage under more than one Plan. When This Plan is primary, it determines payment for its benefits first before those of any other Plan without considering any other Plan's benefits. When This Plan is secondary, it determines its benefits after

those of another Plan and may reduce the benefits it pays so that all Plan benefits do not exceed 100% of the total Allowable Expense.

D. Allowable Expense is a health care expense, including deductibles, coinsurance and copayments, that is covered at least in part by any Plan covering the person. When a Plan provides benefits in the form of services, the reasonable cash value of each service will be considered an Allowable Expense and a benefit paid. An expense that is not covered by any Plan covering the person is not an Allowable Expense. In addition, any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging a Covered Person is not an Allowable Expense.

The following are examples of expenses or services that are not Allowable Expenses:

1. The difference between the cost of a semi-private hospital room and a private room is not an Allowable Expense unless one of the Plans provides coverage for private hospital room expenses.

2. If a person is covered by two or more Plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an Allowable Expense.

3. If a person is covered by two or more Plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable Expense.

4. If a person is covered by one Plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another Plan that provides its benefits or services on the basis of negotiated fees, the Primary Plan's payment arrangement shall be the Allowable Expense for all Plans. However, if the provider has contracted with the Secondary Plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the Primary Plan's payment arrangement and if the provider's contract permits, the negotiated fee or payment shall be the Allowable Expense used by the Secondary Plan to determine its benefits.

5. The amount of any benefit reduction by the Primary Plan because a Covered Person has failed to comply with the Plan provisions is not an Allowable Expense. Examples of these types of plan provisions include second surgical opinions, precertification of admissions, and services.

E. Closed Panel Plan is a Plan that provides health care benefits to Covered Persons primarily in the form of services through a panel of providers that have contracted with or are employed by the Plan, and that excludes benefits for services provided by other providers, except in cases of emergency or referral by a panel member.

F. Custodial Parent is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the calendar year excluding any temporary visitation.

Order of Benefit Determination Rules

When a person is covered by two or more Plans, the rules for determining the order of benefit payments are as follows:

A. The Primary Plan pays or provides its benefits according to its terms of coverage and without regard to the benefits under any other Plan.

B. Except as provided in the next paragraph, a Plan that does not contain a coordination of benefits provision that is consistent with this provision is always primary unless the provisions of both Plans state that the complying plan is primary.

Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage shall be in excess of any other parts of the Plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a Closed Panel Plan to provide out-of-network benefits.

C. A Plan may consider the benefits paid or provided by another Plan in determining its benefits only when it is secondary to that other Plan.

D. Each Plan determines its order of benefits using the first of the following rules that apply:

1. Non-Dependent or Dependent. The Plan that covers the person other than as a dependent, for example as an employee, member, policyholder, subscriber or retiree is the Primary Plan and the Plan that covers the person as a dependent is the Secondary Plan. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Plan covering the person as a dependent; and primary to the Plan covering the person as other than a dependent (e.g. a retired employee); then the order of benefits between the two Plans is reversed so that the Plan covering the person as an employee, member, policyholder, subscriber or retiree is the Secondary Plan and the other Plan is the Primary Plan.

2. Dependent Child Covered Under More Than One Coverage Plan. Unless there is a court decree stating otherwise, plans covering a dependent child shall determine the order of benefits as follows:

a) For a dependent child whose parents are married or are living together, whether or not they have ever been married:

(1) The Plan of the parent whose birthday falls earlier in the calendar year is the Primary Plan; or

(2) If both parents have the same birthday, the Plan that covered the parent longest is the Primary Plan.

b) For a dependent child whose parents are divorced or separated or are not living together, whether or not they have ever been married:

(1) If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. If the parent with responsibility has no health care coverage for the dependent child's health care expenses, but that parent's spouse does, that parent's spouse's plan is the Primary Plan. This shall not apply with respect to any plan year during which benefits are paid or provided before the entity has actual knowledge of the court decree provision.

(2) If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of subparagraph a) above shall determine the order of benefits.

(3) If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of subparagraph a) above shall determine the order of benefits.

(4) If there is no court decree allocating responsibility for the child's health care expenses or health care coverage, the order of benefits for the child are as follows:

(a) The Plan covering the Custodial Parent.

(b) The Plan covering the Custodial Parent's spouse.

(c) The Plan covering the non-Custodial Parent.

(d) The Plan covering the non-Custodial Parent's spouse.

c) For a dependent child covered under more than one plan of individuals who are not the parents of the child, the order of benefits shall be determined, as applicable, under subparagraph a) or b) above as if those individuals were parents of the child.

3. Active Employee or Retired or Laid-off Employee. The Plan that covers a person as an active employee, that is, an employee who is neither laid off nor retired is the Primary Plan. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the other Plan does not have this rule, and, as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D.1. can determine the order of benefits.

4. COBRA or State Continuation Coverage. If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another Plan, the Plan covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the Primary Plan, and the COBRA or state or other federal continuation coverage is the Secondary Plan. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D.1. can determine the order of benefits.

5. Longer or Shorter Length of Coverage. The Plan that covered the person as an employee, member, policyholder, subscriber or retiree longer is the Primary Plan and the Plan that covered the person the shorter period of time is the Secondary Plan.

6. If the preceding rules do not determine the order of benefits, the Allowable Expenses shall be shared equally between the Plans meeting the definition of Plan. In addition, This Plan will not pay more than it would have paid had it been the Primary Plan.

Effect on the Benefits of This Plan

A. When This Plan is secondary, the total benefits paid or provided by all Plans will not be more than the total Allowable Expenses. In determining the amount to be paid for any claim, the Secondary Plan will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any Allowable Expense under its Plan that is unpaid by the Primary Plan. The Secondary Plan may then reduce its payment by the amount so that, when combined with the amount paid by the Primary Plan, the total benefits paid or provided by all Plans for the claim do not exceed the total Allowable Expense for that claim. In addition, the Secondary Plan shall credit to its plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.

B. If a Covered Person is enrolled in two or more Closed Panel Plans and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one Closed Panel Plan, COB shall not apply between that Plan and other Closed Panel Plans.

Right to Receive and Release Needed Information

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under This Plan and other Plans. We may get the facts we need from, or give them to, other organizations or persons for the purpose of applying these rules and determining benefits payable under This Plan and other Plans covering the person claiming benefits.

We need not tell, or get the consent of, any person to do this. Each person claiming benefits under This Plan must give us any facts we need to apply those rules and determine benefits payable. If you do not provide us the information we need to apply these rules and determine the Benefits payable, your claim for Benefits will be denied.

Payments Made

A payment made under another Plan may include an amount that should have been paid under This Plan. If it does, we may pay that amount to the organization that made the payment. That amount will then be treated as though it were a benefit paid under This Plan. We will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means reasonable cash value of the benefits provided in the form of services.

Right of Recovery

If the amount of the payments we made is more than we should have paid under this COB provision, we may recover the excess from one or more of the persons we have paid or for whom we have paid; or any other person or organization that may be responsible for the benefits or services provided for you. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

Section 8: General Legal Provisions

Your Relationship with Us

In order to make choices about your health care coverage and treatment, we believe that it is important for you to understand how we interact with your Enrolling Group's Benefit plan and how it may affect you. We help finance or administer the Enrolling Group's Benefit plan in which you are enrolled. We do not provide medical services or make treatment decisions. This means:

- We do not decide what care you need or will receive. You and your Physician make those decisions.
- We communicate to you decisions about whether the Enrolling Group's Benefit plan will cover or pay for the health care that you may receive. The plan pays for Covered Health Services, which are more fully described in this *Certificate*.
- The plan may not pay for all treatments you or your Physician may believe are necessary. If the plan does not pay, you will be responsible for the cost.

We may use individually identifiable information about you to identify for you (and you alone) procedures, products or services that you may find valuable. We will use individually identifiable information about you as permitted or required by law, including in our operations and in our research. We will use de-identified data for commercial purposes including research.

Please refer to our *Notice of Privacy Practices* for details.

Our Relationship with Providers and Enrolling Groups

The relationships between us and Network providers and Enrolling Groups are solely contractual relationships between independent contractors. Network providers and Enrolling Groups are not our agents or employees. Neither we nor any of our employees are agents or employees of Network providers or the Enrolling Groups.

We do not provide health care services or supplies, nor do we practice medicine. Instead, we arrange for health care providers to participate in a Network and we pay Benefits. Network providers are independent practitioners who run their own offices and facilities. Our credentialing process confirms public information about the providers' licenses and other credentials, but does not assure the quality of the services provided. They are not our employees nor do we have any other relationship with Network providers such as principal-agent or joint venture. We are not liable for any act or omission of any provider.

We are not considered to be an employer for any purpose with respect to the administration or provision of benefits under the Enrolling Group's Benefit plan. We are not responsible for fulfilling any duties or obligations of an employer with respect to the Enrolling Group's Benefit plan.

The Enrolling Group is solely responsible for all of the following:

- Enrollment and classification changes (including classification changes resulting in your enrollment or the termination of your coverage).
- The timely payment of the Policy Charge to us.
- Notifying you of the termination of the Policy.

When the Enrolling Group purchases the Policy to provide coverage under a benefit plan governed by the *Employee Retirement Income Security Act* ("ERISA"), 29 U.S.C. §1001 et seq., we are not the plan administrator or named fiduciary of the benefit plan, as those terms are used in ERISA. If you have questions about your welfare benefit plan, you should contact the Enrolling Group. If you have any

questions about this statement or about your rights under ERISA, contact the nearest area office of the *Employee Benefits Security Administration, U. S. Department of Labor*.

Your Relationship with Providers and Enrolling Groups

The relationship between you and any provider is that of provider and patient.

- You are responsible for choosing your own provider.
- You are responsible for paying, directly to your provider, any amount identified as a member responsibility, including Copayments, Coinsurance, any Annual Deductible and any amount that exceeds Eligible Expenses.
- You are responsible for paying, directly to your provider, the cost of any non-Covered Health Service.
- You must decide if any provider treating you is right for you. This includes Network providers you choose and providers to whom you have been referred.
- You must decide with your provider what care you should receive.
- Your provider is solely responsible for the quality of the services provided to you.

The relationship between you and the Enrolling Group is that of employer and employee, Dependent or other classification as defined in the Policy.

Notice

When we provide written notice regarding administration of the Policy to an authorized representative of the Enrolling Group, that notice is deemed notice to all affected Subscribers and their Enrolled Dependents. The Enrolling Group is responsible for giving notice to you.

Statements by Enrolling Group or Subscriber

All statements made by the Enrolling Group or by a Subscriber shall, in the absence of fraud, be deemed representations and not warranties. Except for fraudulent statements, we will not use any statement made by the Enrolling Group to void the Policy after it has been in force for a period of two years.

Incentives to Providers

We pay Network providers through various types of contractual arrangements, some of which may include financial incentives to promote the delivery of health care in a cost efficient and effective manner. These financial incentives are not intended to affect your access to health care.

Incentives to You

Sometimes we may offer coupons or other incentives to encourage you to participate in various wellness programs or certain disease management programs. The decision about whether or not to participate is yours alone but we recommend that you discuss participating in such programs with your Physician. These incentives are not Benefits and do not alter or affect your Benefits. Contact us if you have any questions.

Interpretation of Benefits

We have the discretion in accordance with state and federal law, to do all of the following:

- Interpret Benefits under the Policy.
- Interpret the other terms, conditions, limitations and exclusions set out in the Policy, including this *Certificate*, the *Schedule of Benefits*, and any Riders and/or Amendments.
- Make factual determinations related to the Policy and its Benefits.

We may delegate this discretionary authority to other persons or entities that provide services in regard to the administration of the Policy.

In certain circumstances, for purposes of overall cost savings or efficiency, we may, in our discretion, offer Benefits for services that would otherwise not be Covered Health Services. The fact that we do so in any particular case shall not in any way be deemed to require us to do so in other similar cases.

Administrative Services

We may, in our sole discretion, arrange for various persons or entities to provide administrative services in regard to the Policy, such as claims processing. The identity of the service providers and the nature of the services they provide may be changed from time to time in our sole discretion. We are not required to give you prior notice of any such change, nor are we required to obtain your approval. You must cooperate with those persons or entities in the performance of their responsibilities.

Amendments to the Policy

To the extent permitted by law we reserve the right, in our sole discretion and without your approval, to change, interpret, modify, withdraw or add Benefits or terminate the Policy.

Any provision of the Policy which, on its effective date, is in conflict with the requirements of state or federal statutes or regulations (of the jurisdiction in which the Policy is delivered) is hereby amended to conform to the minimum requirements of such statutes and regulations.

No other change may be made to the Policy unless it is made by an Amendment or Rider which has been signed by one of our officers. All of the following conditions apply:

- Amendments to the Policy are effective 31 days after we send written notice to the Enrolling Group.
- Riders are effective on the date we specify.
- No agent has the authority to change the Policy or to waive any of its provisions.
- No one has authority to make any oral changes or amendments to the Policy.

Information and Records

We may use your individually identifiable health information to administer the Policy and pay claims, to identify procedures, products, or services that you may find valuable, and as otherwise permitted or required by law. We may request additional information from you to decide your claim for Benefits. We will keep this information confidential. We may also use your de-identified data for commercial purposes, including research, as permitted by law. More detail about how we may use or disclose your information is found in our *Notice of Privacy Practices*.

By accepting Benefits under the Policy, you authorize and direct any person or institution that has provided services to you to furnish us with all information or copies of records relating to the services provided to you. We have the right to request this information at any reasonable time. This applies to all Covered Persons, including Enrolled Dependents whether or not they have signed the Subscriber's enrollment form. We agree that such information and records will be considered confidential.

We have the right to release any and all records concerning health care services which are necessary to implement and administer the terms of the Policy, for appropriate medical review or quality assessment, or as we are required to do by law or regulation. During and after the term of the Policy, we and our related entities may use and transfer the information gathered under the Policy in a de-identified format for commercial purposes, including research and analytic purposes. Please refer to our Notice of Privacy Practices.

For complete listings of your medical records or billing statements we recommend that you contact your health care provider. Providers may charge you reasonable fees to cover their costs for providing records or completing requested forms.

If you request medical forms or records from us, we also may charge you reasonable fees to cover costs for completing the forms or providing the records.

In some cases, as permitted by law, we will designate other persons or entities to request records or information from or related to you, and to release those records as necessary. Our designees have the same rights to this information as we have.

Examination of Covered Persons

In the event of a question or dispute regarding your right to Benefits, we may require that a Network Physician of our choice examine you at our expense.

Workers' Compensation not Affected

Benefits provided under the Policy do not substitute for and do not affect any requirements for coverage by workers' compensation insurance.

Subrogation

Subrogation is the substitution of one person or entity in the place of another with reference to a lawful claim, demand or right. Immediately upon paying or providing any Benefit, we shall be subrogated to any type of recovery for the reasonable value of any services and Benefits we provided to you.

Reimbursement

Reimbursement is the payment by you out of the recovery received from any third party to us to be limited to the amount of medical Benefits paid by us. We may request and receive reimbursement of any type of recovery for the reasonable value of any services and Benefits we provided to you. We may receive reimbursement for the total amount of past Benefits paid, not to exceed the amount you receive from any third party.

You agree as follows:

- That you will cooperate with us in protecting our legal and equitable rights to subrogation and reimbursement, including, but not limited to:
  - Providing any relevant information requested by us.
  - Signing and/or delivering such documents as we or our agents reasonably request to secure the subrogation and reimbursement claim.
  - Responding to requests for information about any accident or injuries.
  - Making court appearances.

  - Obtaining our consent or our agents' consent before releasing any party from liability or payment of medical expenses.

- That failure to cooperate in this manner shall be deemed by us to be a breach of contract, and may result in the instigation of legal action against you.
- That no court costs or attorneys' fees may be deducted from our recovery without our express written consent; any so-called "Fund Doctrine" or "Common Fund Doctrine" or "Attorney's Fund Doctrine" shall not defeat this right, and we are not required to participate in or pay court costs or attorneys' fees to the attorney hired by you to pursue your damage/personal injury claim.
- That regardless of whether you have been fully compensated or made whole, we may collect from you the proceeds of any full or partial recovery that you or your legal representative obtain, whether in the form of a settlement (either before or after any determination of liability) or judgment, with such proceeds available for collection to include any and all amounts earmarked as non-economic damage settlement or judgment.
- That you agree that if you receive any payment from any potentially responsible party as a result of an Injury or Sickness, whether by settlement (either before or after any determination of liability), or judgment, you will serve as a constructive trustee over the funds, and failure to hold such funds in trust will be deemed by us to be a breach of your duties hereunder.
- That you or an authorized agent, such as your attorney, must hold any funds due and owing us, as stated herein, separately and alone, and failure to hold funds as such will be deemed by us to be a breach of contract, and may result in the instigation of legal action against you.
- You will not do anything to prejudice our rights under this provision.
- That you will assign to us all rights of recovery against Third Parties, to the extent of the reasonable value of services and Benefits we provided.
- That our rights will be considered as the first priority claim against Third Parties, including tortfeasors from whom you are seeking recovery, to be paid before any other of your claims are paid.
- That we may, at our option, take necessary and appropriate action to preserve our rights under these subrogation provisions, including filing suit in your name, which does not obligate us in any way to pay you part of any recovery we might obtain.
- That we shall not be obligated in any way to pursue this right independently or on your behalf.
- That in the case of your wrongful death, the provisions of this section will apply to your estate, the personal representative of your estate, and your heirs.
- That the provisions of this section apply to the parents, guardian, or other representative of a Dependent child who incurs a Sickness or Injury caused by a Third Party. If a parent or guardian may bring a claim for damages arising out of a minor's Injury, the terms of this subrogation and reimbursement clause shall apply to that claim.

In addition to any rights and in consideration of the coverage provided by this *Certificate*, we shall also have an independent right to be reimbursed by you for the reasonable value of any services and Benefits we provide to you, from any or all of the following listed below.

- Third parties, including any person alleged to have caused you to suffer injuries or damages.
- Your employer.
- Any person or entity who is or may be obligated to provide benefits or payments to you, including benefits or payments for underinsured or uninsured motorist protection, no-fault or traditional auto

insurance, medical payment coverage (auto, homeowners or otherwise), workers' compensation coverage, other insurance carriers or third party administrators.

- Any person or entity who is liable for payment to you on any equitable or legal liability theory. These persons or entities are collectively referred to as "Third Parties".

Refund of Overpayments

If we pay Benefits for expenses incurred on account of a Covered Person, that Covered Person, or any other person or organization that was paid, must make a refund to us if any of the following apply:

- All or some of the expenses were not paid by the Covered Person or did not legally have to be paid by the Covered Person.
- All or some of the payment we made exceeded the Benefits under the Policy.
- All or some of the payment was made in error.

The refund equals the amount we paid in excess of the amount we should have paid under the Policy. If the refund is due from another person or organization, the Covered Person agrees to help us get the refund when requested.

If the Covered Person, or any other person or organization that was paid, does not promptly refund the full amount, we may reduce the amount of any future Benefits for the Covered Person that are payable under the Policy. The reductions will equal the amount of the required refund. We may have other rights in addition to the right to reduce future benefits.

Limitation of Action

If you want to bring a legal action against us you must do so within three years of the date we notified you of our final decision on your appeal or you lose any rights to bring such an action against us.

Entire Policy

The Policy issued to the Enrolling Group, including this *Certificate*, the *Schedule of Benefits*, the Enrolling Group's application, and any Riders and/or Amendments, constitutes the entire Policy.

Section 9: Defined Terms

Adverse Determination - a determination by us or our designee that the health care service that has been furnished to a Covered Person, or that is proposed to be furnished to a Covered Person, is not medically necessary, or it does not meet the definition of a Covered Health Service because it is not consistent with nationally recognized scientific evidence or prevailing medical standards and clinical guidelines.

Alternate Facility - a health care facility that is not a Hospital and that provides one or more of the following services on an outpatient basis, as permitted by law:

- Surgical services.
- Emergency Health Services.
- Rehabilitative, laboratory, diagnostic or therapeutic services.

An Alternate Facility may also provide Mental Health Services or Substance Use Disorder Services on an outpatient or inpatient basis, and includes a Crisis Stabilization Unit, a Psychiatric Day Treatment Facility, a Mental Health Center, and a Residential Treatment Center for Children and Adolescents.

Amendment - any attached written description of additional or alternative provisions to the Policy. Amendments are effective only when signed by us. Amendments are subject to all conditions, limitations and exclusions of the Policy, except for those that are specifically amended.

Annual Deductible - for Benefit plans that have an Annual Deductible, this is the amount of Eligible Expenses you must pay for Covered Health Services per year before we will begin paying for Benefits. The amount that is applied to the Annual Deductible is calculated on the basis of Eligible Expenses. The Annual Deductible does not include any amount that exceeds Eligible Expenses. Refer to the *Schedule of Benefits* to determine whether or not your Benefit plan is subject to payment of an Annual Deductible and for details about how the Annual Deductible applies.

Assisted Living Facility - a facility regulated by Chapter 247 of the Health and Safety Code.

Autism Spectrum Disorders - a group of Neurobiological Disorders that includes *Autistic Disorder, Rhett's Syndrome, Asperger's Disorder, Childhood Disintegrated Disorder*, and *Pervasive Development Disorders Not Otherwise Specified (PDDNOS)*.

Benefits - your right to payment for Covered Health Services that are available under the Policy. Your right to Benefits is subject to the terms, conditions, limitations and exclusions of the Policy, including this *Certificate*, the *Schedule of Benefits*, and any attached Riders and/or Amendments.

Chemical Dependency - the abuse of, a psychological or physical dependence on, or an addiction to alcohol or a controlled substance. For the purposes of this definition, "controlled substance" means an abusable volatile chemical, as defined by Section 485.001, Health and Safety Code, or a substance designated as a controlled substance under Chapter 481, Health and Safety Code.

Coinsurance - the charge, stated as a percentage of Eligible Expenses, that you are required to pay for certain Covered Health Services.

Complications of Pregnancy - a condition that requires treatment during a Pregnancy or during the post-partum period that requires a Hospital confinement (when the Pregnancy is not terminated), whose diagnoses are distinct from Pregnancy but are adversely affected by Pregnancy or are caused by Pregnancy, such as acute nephritis, nephrosis, cardiac decompensation, missed abortion, and similar medical and surgical conditions of comparable severity, but shall not include false labor, occasional spotting, Physician prescribed rest during the period of Pregnancy, morning sickness, hyperemesis gravidarum, pre-eclampsis, and similar conditions associated with the management of a difficult Pregnancy not constituting a nosologically distinct complication of Pregnancy; and non-elective cesarean

section, termination of ectopic Pregnancy, and spontaneous termination of Pregnancy, occurring during a period of gestation in which a viable birth is not possible.

Congenital Anomaly - a physical developmental defect that is present at the time of birth, and that is identified within the first twelve months of birth.

Continuous Creditable Coverage - health care coverage under any of the types of plans listed below, during which there was no break in coverage of 63 consecutive days or more:

- A group health plan.
- Health insurance coverage.
- Medicare.
- Medicaid.
- Medical and dental care for members and certain former members of the uniformed services, and for their dependents.
- A medical care program of the *Indian Health Services Program* or a tribal organization.
- A state health benefits risk pool.
- *The Federal Employees Health Benefits Program*.
- *The State Children's Health Insurance Program (S-CHIP)*.
- Health plans established and maintained by foreign governments or political subdivisions and by the U.S. government.
- Any public health benefit program provided by a state, county, or other political subdivision of a state.
- A health benefit plan under the *Peace Corps Act*.
- Short-term limited duration coverage plan.

A waiting period for health care coverage will be included in the period of time counted as Continuous Creditable Coverage.

Copayment - the charge, stated as a set dollar amount, that you are required to pay for certain Covered Health Services.

Please note that for Covered Health Services, you are responsible for paying the lesser of the following:

- The applicable Copayment.
- The Eligible Expense.

Cosmetic Procedures - procedures or services that change or improve appearance without significantly improving physiological function, as determined by us.

Covered Health Service(s) - those health services, including services, supplies, or Pharmaceutical Products, which we determine to be all of the following:

- Provided for the purpose of preventing, diagnosing or treating a Sickness, Injury, Mental Illness, substance use disorders, or their symptoms.
- Consistent with nationally recognized scientific evidence as available, and prevailing medical standards and clinical guidelines as described below.

- Not provided for the convenience of the Covered Person, Physician, facility or any other person.
- Described in this *Certificate* under *Section 1: Covered Health Services* and in the *Schedule of Benefits*.
- Not otherwise excluded in this *Certificate* under *Section 2: Exclusions and Limitations*.

In applying the above definition, "scientific evidence" and "prevailing medical standards" shall have the following meanings:

- "Scientific evidence" means the results of controlled clinical trials or other studies published in peer-reviewed, medical literature generally recognized by the relevant medical specialty community.
- "Prevailing medical standards and clinical guidelines" means nationally recognized professional standards of care including, but not limited to, national consensus statements, nationally recognized clinical guidelines, and national specialty society guidelines.

We maintain clinical protocols that describe the scientific evidence, prevailing medical standards and clinical guidelines supporting our determinations regarding specific services. These clinical protocols (as revised from time to time), are available to Covered Persons on www.myuhc.com or by calling *Customer Care* at the telephone number on your ID card, and to Physicians and other health care professionals on UnitedHealthcareOnline.

Covered Person - either the Subscriber or an Enrolled Dependent, but this term applies only while the person is enrolled under the Policy. References to "you" and "your" throughout this *Certificate* are references to a Covered Person.

Crisis Stabilization Unit - a 24-hour residential program that is usually short-term in nature and that provides intensive supervision and highly structure activities to persons who are demonstrating an acute demonstrable psychiatric crisis of moderate to severe proportions.

Custodial Care - services that are any of the following:

- Non-health-related services, such as assistance in activities of daily living (examples include feeding, dressing, bathing, transferring and ambulating).
- Health-related services that are provided for the primary purpose of meeting the personal needs of the patient or maintaining a level of function (even if the specific services are considered to be skilled services), as opposed to improving that function to an extent that might allow for a more independent existence.
- Services that do not require continued administration by trained medical personnel in order to be delivered safely and effectively.

Dependent - the Subscriber's legal spouse, including a common law spouse, or an unmarried dependent child of the Subscriber or the Subscriber's spouse. All references to the spouse of a Subscriber shall include a Domestic Partner. The term child includes any of the following:

- A natural child.
- A stepchild.
- A legally adopted child.
- A child placed for adoption.
- A child for whom the Subscriber is a party in suit seeking adoption.
- A child for whom legal guardianship has been awarded to the Subscriber or the Subscriber's spouse.

- A grandchild of the Subscriber who is a Dependent of the Subscriber for federal income tax purposes at the time the application for coverage of the grandchild is made
- Any unmarried dependent child of any age who is medically certified as disabled and dependent upon the Subscriber.

The marital status or lack of marital status between the Subscriber and the other parent will not be a factor in determining a Dependent's eligibility.

The definition of Dependent is subject to the following conditions and limitations:

- A Dependent includes any unmarried dependent child under 25 years of age.
- A Dependent includes an unmarried dependent child of any age who is or becomes disabled and is incapable of self-sustaining employment because of mental retardation or physical disability and is chiefly dependent upon the Subscriber for support and maintenance.

The Subscriber must reimburse us for any Benefits that we pay for a child at a time when the child did not satisfy these conditions.

A Dependent also includes a child for whom health care coverage is required through a *Qualified Medical Child Support Order* or other court or administrative order. The Enrolling Group is responsible for determining if an order meets the criteria of a *Qualified Medical Child Support Order*.

A Dependent does not include anyone who is also enrolled as a Subscriber. No one can be a Dependent of more than one Subscriber.

Designated Facility - a facility that has entered into an agreement with us, or with an organization contracting on our behalf, to render Covered Health Services for the treatment of specified diseases or conditions. A Designated Facility may or may not be located within your geographic area. The fact that a Hospital is a Network Hospital does not mean that it is a Designated Facility.

Designated Network Benefits - for Benefit plans that have a Designated Network Benefit level, this is the description of how Benefits are paid for Covered Health Services provided by a Physician or other provider that we have identified as Designated Network providers. Refer to the *Schedule of Benefits* to determine whether or not your Benefit plan offers Designated Network Benefits and for details about how Designated Network Benefits apply.

Designated Physician - a Physician that we've identified through our designation programs as a Designated provider. A Designated Physician may or may not be located within your geographic area. The fact that a Physician is a Network Physician does not mean that he or she is a Designated Physician.

Domestic Partner - a person of the opposite or same sex with whom the Subscriber has established a Domestic Partnership.

Domestic Partnership - a relationship between a Subscriber and one other person of the opposite or same sex. All of the following requirements apply to both persons:

- They must not be currently married to, or a Domestic Partner of, another person under either statutory or common law.
- They must share the same permanent residence and the common necessities of life.
- They must be at least 18 years of age.
- They must be mentally competent to consent to contract.

Durable Medical Equipment - medical equipment that is all of the following:

- Can withstand repeated use.

- Is not disposable.
- Is used to serve a medical purpose with respect to treatment of a Sickness, Injury or their symptoms.
- Is generally not useful to a person in the absence of a Sickness, Injury or their symptoms.
- Is appropriate for use, and is primarily used, within the home.
- Is not implantable within the body.

Eligible Expenses - for Covered Health Services, incurred while the Policy is in effect, Eligible Expenses are determined by us as stated below and as detailed in the *Schedule of Benefits*.

Eligible Expenses are determined solely in accordance with our reimbursement policy guidelines. We develop our reimbursement policy guidelines, in our discretion, following evaluation and validation of all provider billings in accordance with one or more of the following methodologies:

- As indicated in the most recent edition of the *Current Procedural Terminology (CPT)*, a publication of the *American Medical Association*, and/or the *Centers for Medicare and Medicaid Services (CMS)*.
- As reported by generally recognized professionals or publications.
- As used for Medicare.
- As determined by medical staff and outside medical consultants pursuant to other appropriate source or determination that we accept.

Eligible Person - an employee of the Enrolling Group or other person whose connection with the Enrolling Group meets the eligibility requirements specified in both the application and the Policy.

Emergency - a serious medical condition or symptom resulting from Injury, Sickness or Mental Illness which is both of the following:

- Arises suddenly.
- Manifests itself by acute symptoms of a recent onset and severity, including severe pain, such that the absence of immediate medical attention could cause a prudent layperson, possessing an average knowledge of medicine and health, to believe that failure to get immediate medical care may result in any of the following:
  - Placing the patient's health in serious jeopardy.
  - Serious impairment to bodily functions.
  - Serious dysfunction of any bodily organ or part.
  - Serious disfigurement.
  - In the case of a pregnant woman, serious jeopardy to the health of the fetus.

Emergency Health Services - health care services and supplies necessary for the treatment of an Emergency.

Enrolled Dependent - a Dependent who is properly enrolled under the Policy.

Enrolling Group - the employer, or other defined or otherwise legally established group, to whom the Policy is issued.

Experimental or Investigational Service(s) - medical, surgical, diagnostic, psychiatric, mental health, substance use disorders or other health care services, technologies, supplies, treatments, procedures,

drug therapies, medications or devices that, at the time we make a determination regarding coverage in a particular case, are determined to be any of the following:

- Not approved by the *U.S. Food and Drug Administration* (*FDA*) to be lawfully marketed for the proposed use and not identified in the *American Hospital Formulary Service* or the *United States Pharmacopoeia Dispensing Information* as appropriate for the proposed use.
- Subject to review and approval by any institutional review board for the proposed use. (Devices which are *FDA* approved under the *Humanitarian Use Device* exemption are not considered to be Experimental or Investigational.)
- The subject of an ongoing clinical trial that meets the definition of a Phase 1, 2, 3 or 4 clinical trial set forth in the *FDA* regulations, regardless of whether the trial is actually subject to *FDA* oversight.

Exceptions:

- Clinical trials for which Benefits are available as described under *Clinical Trials* in *Section 1: Covered Health Services*.
- Life-Threatening Sickness or Condition. If you have a life-threatening Sickness or condition (one that is likely to cause death within one year of the request for treatment) we may, in our discretion, consider an otherwise Experimental or Investigational Service to be a Covered Health Service for that Sickness or condition. Prior to such a consideration, we must first establish that there is sufficient evidence to conclude that, albeit unproven, the service has significant potential as an effective treatment for that Sickness or condition, and that the service would be provided under standards equivalent to those defined by the *National Institutes of Health*.

These criteria shall not apply for drugs prescribed to treat a chronic, disabling, or life-threatening illness if the drug is both of the following:

- Has been approved by the *FDA* for at least one indication.
- Is recognized for treatment of the indication for which the drug is prescribed in either of the following:
  - A prescription drug reference compendium approved by the *Commissioner of the Texas Department of Insurance*.
  - Substantially accepted peer-reviewed medical literature.

Freestanding Emergency Medical Care Facility - a facility, structurally separate and distinct from a Hospital that receives an individual and provides Emergency care.

Home Health Agency - a program or organization authorized by law to provide health care services in the home.

Hospital - an institution that is operated as required by law and that meets both of the following:

- It is primarily engaged in providing health services, on an inpatient basis, for the acute care and treatment of injured or sick individuals. Care is provided through medical, diagnostic and surgical facilities, by or under the supervision of a staff of Physicians.
- It has 24-hour nursing services.

A Hospital is not primarily a place for rest, Custodial Care or care of the aged and is not a nursing home, convalescent home or similar institution.

Independent Review Organization (*IRO*) - an organization certified by the State of Texas to hear appeals of Adverse Determinations.

Initial Enrollment Period - the initial period of time during which Eligible Persons may enroll themselves and their Dependents under the Policy.

Injury - bodily damage other than Sickness, including all related conditions and recurrent symptoms.

Inpatient Rehabilitation Facility - a Hospital (or a special unit of a Hospital that is designated as an Inpatient Rehabilitation Facility) that provides rehabilitation health services (physical therapy, occupational therapy and/or speech therapy) on an inpatient basis, as authorized by law.

Inpatient Stay - an uninterrupted confinement that follows formal admission to a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility.

Intensive Outpatient Treatment - a structured outpatient Mental Health or Substance Use Disorder treatment program that may be free-standing or Hospital-based and provides services for at least three hours per day, two or more days per week.

Intermediate Care - Mental Health/Substance Use Disorder Services that encompasses the following:

- Care at a Residential Treatment Facility which provides a program of effective Mental Health/Substance Use Disorder Services and treatment and meets all of the following requirements:
  - It is established and operated in accordance with any applicable state law.
  - It provides a program of treatment approved by a Physician and us.
  - It has or maintains a written, specific and detailed regimen requiring full-time residence and full-time participation by the patient.
  - It provides at least the following basic services:
    - Room and board.
    - Evaluation and diagnosis.
    - Counseling.
    - Referral and orientation to specialized community resources.
- Care at a Partial Hospitalization/Day Treatment program, which is a freestanding or Hospital-based program that provides services for at least 20 hours per week.
- Care through an Intensive Outpatient Treatment program, which is a freestanding or Hospital-based program that provides services for at least nine hours per week. This encompasses half-day (i.e. less than four hours per day) partial Hospital programs.

Intermittent Care - skilled nursing care that is provided or needed either:

- Fewer than seven days each week.
- Fewer than eight hours each day for periods of 21 days or less.

Exceptions may be made in exceptional circumstances when the need for additional care is finite and predictable.

Manipulative Treatment - the therapeutic application of chiropractic and/or osteopathic manipulative treatment with or without ancillary physiologic treatment and/or rehabilitative methods rendered to restore/improve motion, reduce pain and improve function in the management of an identifiable neuromusculoskeletal condition.

Maximum Policy Benefit - for Benefit plans that have a Maximum Policy Benefit, this is the maximum amount that we will pay for Benefits during the entire period of time that you are enrolled under the Policy

issued to the Enrolling Group. Refer to the *Schedule of Benefits* to determine whether or not your Benefit plan is subject to a Maximum Policy Benefit and for details about how the Maximum Policy Benefit applies.

Medicare - Parts A, B, C and D of the insurance program established by Title XVIII, United States Social Security Act, as amended by 42 U.S.C. Sections 1394, et seq. and as later amended.

Mental Health Center - a tax supported institution of the State of Texas, including community centers for mental health and mental retardation services.

Mental Health Services - Covered Health Services for the diagnosis and treatment of Mental Illnesses. The fact that a condition is listed in the current *Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment for the condition is a Covered Health Service.

Mental Illness - those mental health or psychiatric diagnostic categories (including Serious Mental Illnesses) that are listed in the current *Diagnostic and Statistical Manual of the American Psychiatric Association*, unless those services are specifically excluded under the Policy.

Network - when used to describe a provider of health care services, this means a provider that has a participation agreement in effect (either directly or indirectly) with us or with our affiliate to participate in our Network; however, this does not include those providers who have agreed to discount their charges for Covered Health Services by way of their participation in the Shared Savings Program. Our affiliates are those entities affiliated with us through common ownership or control with us or with our ultimate corporate parent, including direct and indirect subsidiaries.

A provider may enter into an agreement to provide only certain Covered Health Services, but not all Covered Health Services, or to be a Network provider for only some of our products. In this case, the provider will be a Network provider for the Covered Health Services and products included in the participation agreement, and a non-Network provider for other Covered Health Services and products. The participation status of providers will change from time to time.

Network Benefits - the description of how Benefits are paid for Covered Health Services provided by Network providers. Refer to the *Schedule of Benefits* to determine whether or not your Benefit plan offers Network Benefits and for details about how Network Benefits apply.

Neurobiological Disorder - an illness of the nervous system caused by genetic, metabolic or other biological factors.

Non-clinical Benefit Determination - a determination made by us that proposed or delivered services are or are not covered services according to the terms of the insurance Policy without reference to the medical necessity or appropriateness of the services. A Non-clinical Benefit Determination that services are not covered is not an Adverse Determination.

Non-Network Benefits - the description of how Benefits are paid for Covered Health Services provided by non-Network providers. Refer to the *Schedule of Benefits* for details about how Non-Network Benefits apply.

Open Enrollment Period - a period of time that follows the Initial Enrollment Period during which Eligible Persons may enroll themselves and Dependents under the Policy. The Enrolling Group determines the period of time that is the Open Enrollment Period.

Orthotic Device - a custom-fitted or custom-fabricated medical device that is applied to a part of the human body to correct a deformity, improve function or relieve symptoms of a disease. Dental devices (for example: braces, dentures, bridges) are not considered as Orthotic Devices.

Out-of-Pocket Maximum - for Benefit plans that have an Out-of-Pocket Maximum, this is the maximum amount you pay every year. Refer to the *Schedule of Benefits* to determine whether or not your Benefit plan is subject to an Out-of-Pocket Maximum and for details about how the Out-of-Pocket Maximum applies.

Partial Hospitalization/Day Treatment - a structured ambulatory program that may be a free-standing or Hospital-based program and that provides services for at least 20 hours per week.

Pharmaceutical Product(s) - *FDA*-approved prescription pharmaceutical products administered in connection with a Covered Health Service by a Physician or other health care provider within the scope of the provider's license, and not otherwise excluded under the Policy.

Physician - any *Doctor of Medicine* or *Doctor of Osteopathy* who is properly licensed and qualified by law.

Please Note: Any acupuncturist, advanced practice nurse, audiologist, chemical dependency counselor, chiropractor, dentist, dietitian, hearing instrument fitter or dispenser, licensed clinical social worker, licensed professional counselor, marriage and family therapist, occupational therapist, optometrist, orthotist, physical therapist, physician assistant, podiatrist, prosthetist, psychological associate, psychologist, speech-language pathologist, surgical assistant or other provider who acts within the scope of his or her license will be considered on the same basis as a Physician. The fact that we describe a provider as a Physician does not mean that Benefits for services from that provider are available to you under the Policy.

Policy - the entire agreement issued to the Enrolling Group that includes all of the following:

- The *Group Policy*.
- This *Certificate*.
- The *Schedule of Benefits*.
- The Enrolling Group's application.
- Riders.
- Amendments.

These documents make up the entire agreement that is issued to the Enrolling Group.

Policy Charge - the sum of the Premiums for all Subscribers and Enrolled Dependents enrolled under the Policy.

Post-acute Care Treatment Services - Services provided after acute care confinement and/or treatment, which are based on an assessment of the individual's cognitive deficits, which include a treatment goal of achieving functional changes by reinforcing, strengthening, or re-establishing previously learned patterns of behavior and/or establishing new patterns of cognitive activity or compensatory mechanisms.

Post-acute Transition Services - Services that facilitate the continuum of care beyond the initial neurological insult through rehabilitation and community reintegration.

Pre-authorization - a determination that medical care or health care services proposed to be provided to a Covered Person are medically necessary and appropriate.

Preexisting Condition - an Injury or Sickness that was diagnosed or treated, or for which prescription medications or drugs were prescribed or taken within the three month period ending on the person's enrollment date. (The enrollment date is the date the person became covered under the Policy or, if earlier, the first day of any waiting period under the Policy.) A Preexisting Condition does not include Pregnancy. Genetic information is not an indicator of a Preexisting Condition, if there is not a diagnosis of a condition related to the genetic information.

Pregnancy - includes all of the following:

- Prenatal care.

- Postnatal care.
- Childbirth.
- Any complications associated with Pregnancy.

Premium - the periodic fee required for each Subscriber and each Enrolled Dependent, in accordance with the terms of the Policy.

Primary Physician - a Physician who has a majority of his or her practice in general pediatrics, internal medicine, obstetrics/gynecology, family practice or general medicine.

Private Duty Nursing - nursing care that is provided to a patient on a one-to-one basis by licensed nurses in an inpatient or home setting when any of the following are true:

- No skilled services are identified.
- Skilled nursing resources are available in the facility.
- The skilled care can be provided by a Home Health Agency on a per visit basis for a specific purpose.
- The service is provided to a Covered Person by an independent nurse who is hired directly by the Covered Person or his/her family. This includes nursing services provided on an inpatient or home-care basis, whether the service is skilled or non-skilled independent nursing.

Psychiatric Day Treatment Facility - a mental health facility that provides treatment for individuals suffering from acute mental and nervous disorders in a structured psychiatric program, utilizing individualized treatment plans with specific attainable goals and objectives that are appropriate both to the patient and to the treatment modality of the program. The facility must be clinically supervised by a *Doctor of Medicine* who is certified in psychiatry by the *American Board of Psychiatry and Neurology*.

Request for pre-authorization of services - notification to us of proposed services that will result in any of the following:

- A Pre-authorization.
- An Adverse Determination.
- When there are no clinical issues for us to determine, confirmation of receipt of your request.

Residential Treatment Facility - a facility which provides a program of effective Mental Health Services or Substance Use Disorder Services treatment and which meets all of the following requirements:

- It is established and operated in accordance with applicable state law for residential treatment programs.
- It provides a program of treatment under the active participation and direction of a Physician and approved by us.
- It has or maintains a written, specific and detailed treatment program requiring full-time residence and full-time participation by the patient.
- It provides at least the following basic services in a 24-hour per day, structured milieu:
  - Room and board.
  - Evaluation and diagnosis.
  - Counseling.

- Referral and orientation to specialized community resources.

A Residential Treatment Facility that qualifies as a Hospital is considered a Hospital.

Residential Treatment Center for Children and Adolescents - a child-care institution that is both of the following:

- Provides residential care and treatment for emotionally disturbed children and adolescents.
- Accredited as a residential treatment center by any of these:
  - *The Council of Accreditation*.
  - *The Joint Commission on Accreditation of Hospitals*.
  - *The American Association of Psychiatric Services for Children*.

Rider - any attached written description of additional Covered Health Services not described in this *Certificate*. Covered Health Services provided by a Rider may be subject to payment of additional Premiums. Riders are effective only when signed by us and are subject to all conditions, limitations and exclusions of the Policy except for those that are specifically amended in the Rider.

Semi-private Room - a room with two or more beds. When an Inpatient Stay in a Semi-private Room is a Covered Health Service, the difference in cost between a Semi-private Room and a private room is a Benefit only when a private room is necessary in terms of generally accepted medical practice, or when a Semi-private Room is not available.

Series of Treatments - a planned, structured and organized program to promote chemical free status. This program may include different facilities or modalities, and is complete when either of the following occurs:

- The Covered Person is discharged on medical advice from inpatient rehabilitation/treatment, partial hospitalization, or intensive outpatient treatment, or a series of these levels of treatments without a lapse in treatment.
- The Covered Person fails to materially comply with the treatment program for a period of 30 days.

Serious Mental Illness - the following psychiatric illnesses as defined in the current *Diagnostic and Statistical Manual of the American Psychiatric Association*:

- Schizophrenia.
- Paranoid and other psychotic disorders.
- Bipolar disorders (hypomaniac, manic, depressive, and mixed).
- Major depressive disorders (single episode or recurrent).
- Schizo-affective disorders (bipolar or depressive).
- Obsessive-compulsive disorders.
- Depression in childhood and adolescence.

Shared Savings Program - the Shared Savings Program provides access to discounts from the provider's charges when services are rendered by those non-Network providers that participate in that program. We will use the Shared Savings Program to pay claims when doing so will lower Eligible Expenses. We do not credential the Shared Savings Program providers and the Shared Savings Program providers are not Network providers. Accordingly, in Benefit plans that have both Network and Non-Network levels of Benefits, Benefits for Covered Health Services provided by Shared Savings Program providers will be paid at the Non-Network Benefit level (except in situations when Benefits for Covered Health Services provided by non-Network providers are payable at Network Benefit levels, as in the case

of Emergency Health Services). When we use the Shared Savings Program to pay a claim, patient responsibility is limited to Coinsurance calculated on the contracted rate paid to the provider, in addition to any required Annual Deductible.

Sickness - physical illness, disease or Complications of Pregnancy. The term Sickness as used in this *Certificate* does not include Mental Illness or substance use disorders, regardless of the cause or origin of the Mental Illness or substance use disorder.

Skilled Nursing Facility - a Hospital or nursing facility that is licensed and operated as required by law.

Specialist Physician - a Physician who has a majority of his or her practice in areas other than general pediatrics, internal medicine, obstetrics/gynecology, family practice or general medicine.

Subscriber - an Eligible Person who is properly enrolled under the Policy. The Subscriber is the person (who is not a Dependent) on whose behalf the Policy is issued to the Enrolling Group.

Substance Use Disorder Services - Covered Health Services for the diagnosis and treatment of alcoholism and substance use disorders that are listed in the current *Diagnostic and Statistical Manual of the American Psychiatric Association*, unless those services are specifically excluded. The fact that a disorder is listed in the *Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment of the disorder is a Covered Health Service.

Total Disability or Totally Disabled - a Subscriber's inability to perform all of the substantial and material duties of his or her regular employment or occupation; and a Dependent's inability to perform the normal activities of a person of like age and sex.

Transitional Care - Mental Health Services and Substance Use Disorder Services that are provided through transitional living facilities, group homes and supervised apartments that provide 24-hour supervision that are either:

- Sober living arrangements such as drug-free housing, alcohol/drug halfway houses. These are transitional, supervised living arrangements that provide stable and safe housing, an alcohol/drug-free environment and support for recovery. A sober living arrangement may be utilized as an adjunct to ambulatory treatment when treatment doesn't offer the intensity and structure needed to assist the Covered Person with recovery.

- Supervised living arrangements which are residences such as transitional living facilities, group homes and supervised apartments that provide members with stable and safe housing and the opportunity to learn how to manage their activities of daily living. Supervised living arrangements may be utilized as an adjunct to treatment when treatment doesn't offer the intensity and structure needed to assist the Covered Person with recovery.

Unproven Service(s) - services, including medications, that are determined not to be effective for treatment of the medical condition and/or not to have a beneficial effect on health outcomes due to insufficient and inadequate clinical evidence from well-conducted randomized controlled trials or cohort studies in the prevailing published peer-reviewed medical literature.

- Well-conducted randomized controlled trials. (Two or more treatments are compared to each other, and the patient is not allowed to choose which treatment is received.)

- Well-conducted cohort studies. (Patients who receive study treatment are compared to a group of patients who receive standard therapy. The comparison group must be nearly identical to the study treatment group.)

We have a process by which we compile and review clinical evidence with respect to certain health services. From time to time, we issue medical and drug policies that describe the clinical evidence available with respect to specific health care services. These medical and drug policies are subject to change without prior notice. You can view these policies at www.myuhc.com.

Please note:

- If you have a life-threatening Sickness or condition (one that is likely to cause death within one year of the request for treatment) we may, in our discretion, consider an otherwise Unproven Service to be a Covered Health Service for that Sickness or condition. Prior to such a consideration, we must first establish that there is sufficient evidence to conclude that, albeit unproven, the service has significant potential as an effective treatment for that Sickness or condition, and that the service would be provided under standards equivalent to those defined by the *National Institutes of Health*.
- We may, in our discretion, consider an otherwise Unproven Service to be a Covered Health Service for a Covered Person with a Sickness or Injury that is not life-threatening. For that to occur, all of the following conditions must be met:
    - If the service is one that requires review by the *U.S. Food and Drug Administration* (*FDA*), it must be *FDA*-approved.
    - It must be performed by a Physician and in a facility with demonstrated experience and expertise.
    - The Covered Person must consent to the procedure acknowledging that we do not believe that sufficient clinical evidence has been published in peer-reviewed medical literature to conclude that the service is safe and/or effective.
    - At least two studies must be available in published peer-reviewed medical literature that would allow us to conclude that the service is promising but unproven.
    - The service must be available from a Network Physician and/or a Network facility.

The decision about whether such a service can be deemed a Covered Health Service is at our discretion. Other apparently similar promising but unproven services may not qualify.

Prescription drugs prescribed to treat a chronic, disabling or life-threatening illness are covered services if the drug is both of the following:

- Has been approved by the *U.S. Food and Drug Administration (FDA)* for at least one indication.
- Is recognized for treatment of the indication for which the drug is prescribed in either of the following:
    - A prescription drug reference compendium approved by the *Commissioner* of the *Texas Department of Insurance*.
    - Substantially accepted peer-reviewed medical literature.

Urgent Care Center - a facility that provides Covered Health Services that are required to prevent serious deterioration of your health, and that are required as a result of an unforeseen Sickness, Injury, or the onset of acute or severe symptoms.

Utilization Review - a system for prospective, concurrent, or retrospective review of the medical necessity and appropriateness of health care services and a system for prospective, concurrent, or retrospective review to determine the experimental or investigational nature of health care services. The term does not include a review in response to an elective request for clarification of coverage.

Acquired Brain Injury Amendment

United Healthcare Insurance Company

As described in this Amendment, the Policy is modified to provide Benefits for Acquired Brain Injury.

Because this Amendment is part of a legal document (the group Policy), we want to give you information about the document that will help you understand it. Certain capitalized words have special meanings. We have defined these words in the *Certificate of Coverage (Certificate)* in *Section 9: Defined Terms* and in this Amendment below.

1. *Acquired Brain Injury* in the *Certificate, Section 1: Covered Health Services* is replaced with the following:

Acquired Brain Injury

Benefits are provided for Covered Health Services that are determined by a Physician to be medically necessary as a result of and related to an acquired brain injury. Acquired brain injury is a neurological insult to the brain which is not hereditary, congenital or degenerative. The injury to the brain has occurred after birth and results in a change in neuronal activity, which results in an impairment of physical functioning, sensory processing, cognition, or psychosocial behavior. Benefits are provided for the Covered Health Services listed below when they are clinically proven, goal-oriented, efficacious, based on individualized treatment plans, required for and related to treatment of an acquired brain injury and provided by or under the direction of a Physician with the goal of returning the Covered Person to, or maintaining the Covered Person in, the most integrated living environment appropriate to the Covered Person.

- Cognitive communication therapy. Services designed to address modalities of comprehension and expression, including understanding, reading, writing and verbal expression of information.
- Cognitive rehabilitation therapy. Services designed to address therapeutic cognitive activities based on an assessment and understanding of the individual's brain-behavioral deficits.
- Community reintegration services. Services that facilitate the continuum of care as an affected individual transitions into the community.
- Neurobehavioral testing. An evaluation of the history of neurological and psychiatric difficulty, current symptoms, current mental status, and pre-morbid history including the identification of problematic behavior and the relationship between behavior and the variables that control behavior.
- Neurobehavioral treatment. Interventions that focus on behavior and the variables that control behavior.
- Neurocognitive rehabilitation. Services designed to assist cognitively impaired individuals to compensate for deficits in cognitive functioning by rebuilding cognitive skills and/or developing compensatory strategies and techniques.
- Neurocognitive therapy. Services designed to address neurological deficits in informational processing and to facilitate the development of higher level cognitive abilities.
- Neurofeedback therapy. Services that utilize operant conditioning learning procedure based on electroencephalography (EEG) parameters, and which are designed to result in improved mental performance and behavior, and stabilized mood.
- Neurophysiological testing. An evaluation of the functions of the nervous system.

- Neurophysiological treatment. Interventions that focus on the functions of the nervous system.
- Neuropsychological testing. The administering of a comprehensive battery of tests to evaluate neurocognitive, behavioral and emotional strengths and weaknesses and their relationship to normal and abnormal central nervous system functioning.
- Neuropsychological treatment. Interventions designed to improve or minimize deficits in behavioral and cognitive processes.
- Post-acute transition services. Services that facilitate the continuum of care beyond the initial neurological insult through rehabilitation and community reintegration.
- Psychophysiological testing. An evaluation of the interrelationships between the nervous system and other bodily organs and behavior.
- Psychophysiological treatment. Interventions designed to alleviate or decrease abnormal physiological responses of the nervous system due to behavioral or emotional factors.
- Remediation. The process of restoring or improving a specific function.
- Outpatient day treatment services and post-acute care treatment. Services necessary as a result of and related to an acquired brain injury. Post-acute care treatment is limited to reasonable expenses related to periodic reevaluation of care provided to an individual who has incurred an acquired brain injury, has been unresponsive to treatment and becomes responsive to treatment at a later date. Reasonable costs may be determined by cost; the time that has expired since the previous evaluation; any difference in the expertise of the physician or practitioner performing the evaluation; changes in technology and advances in medicine. For services provided by a licensed Assisted Living Facility through a program that includes an overnight stay, each overnight stay is equal to a visit.
- Treatment facilities. Treatment for an acquired brain injury may be provided at a facility at which the services listed above may be provided including a Hospital, acute or post-acute rehabilitation hospital and Assisted Living Facility. Although Benefits are available for services at Assisted Living Facilities, Benefits are not available for Custodial Care, private duty nursing, domiciliary care, and personal care assistants as outlined in *S. Types of Care* in *Section 2: Exclusions and Limitations* of this *Certificate of Coverage* regardless of where the services are provided.

2. The following definition of Assisted Living Facility is added to the *Certificate* under *Section 9: Defined Terms*:

Assisted Living Facility - a facility regulated by Chapter 247 of the *Health and Safety Code*.

When Benefit limits apply, the limit refers to any combination of Network Benefits and Non-Network Benefits unless otherwise specifically stated.			
Covered Health Service	**Benefit** ***(The Amount We Pay, based on Eligible Expenses)***	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
Acquired Brain Injury			
Request for Pre-authorization of Services Requirement You must submit a Request for pre-authorization of services to us. If you don't submit a Request for pre-authorization of services to us, Benefits will be reduced to 50% of Eligible Expenses, however, the reduction in Benefits will not exceed $500.			
Hospital - Inpatient Stay and *Skilled Nursing Facility/Inpatient*	***Network***		

When Benefit limits apply, the limit refers to any combination of Network Benefits and Non-Network Benefits unless otherwise specifically stated.			
Covered Health Service	**Benefit** ***(The Amount We Pay, based on Eligible Expenses)***	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
Rehabilitation Facility Services	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*.		
	Non-Network Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits.*		
Benefits for the following services are limited to 60 visits per year: • Outpatient post-acute care transitional services and post-acute care treatment services, including services provided at a Assisted Living Facility. • Rehabilitative services for physical therapy, occupational therapy, and speech therapy. These Benefits are in addition to those described under *Rehabilitation Services - Outpatient Therapy and Manipulative Treatment.*	***Network*** 90%	Yes	Yes
	Non-Network 70%	Yes	Yes

UNITEDHEALTHCARE INSURANCE COMPANY

Jeffrey Alter, President

Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) Amendment

UnitedHealthcare Insurance Company

As described in this Amendment, the Policy is modified as stated below.

Because this Amendment is part of a legal document (the group Policy), we want to give you information about the document that will help you understand it. Certain capitalized words have special meanings. We have defined these words in the *Certificate of Coverage* (*Certificate*) in *Section 9: Defined Terms* and in this Amendment below.

The Requests for Pre-authorization of Services requirements listed under *Mental Health Services, Neurobiological Disorders - Autism Spectrum Disorder Services* and *Substance Use Disorder Services* in the *Schedule of Benefits* are deleted. The following services are added to the list of services requiring pre-authorization under *Pre-authorization of Services* in the *Schedule of Benefits*:

Requests for Pre-authorization of Services

When you choose to receive certain Covered Health Services from non-Network providers, you are responsible for notifying us before you receive these services.

To notify us, call the telephone number for *Customer Care* on your ID card.

The following Covered Health Services require pre-authorization before services are received, or as soon as reasonably possible:

- Mental Health Services - inpatient services (including Partial Hospitalization/Day Treatment and services at a Residential Treatment Facility); intensive outpatient program treatment; outpatient electro-convulsive treatment; psychological testing; extended outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management; outpatient treatment provided in your home.
- Neurobiological Disorders - Autism Spectrum Disorder Services - inpatient services (including Partial Hospitalization/Day Treatment and services at a Residential Treatment Facility), intensive outpatient program treatment; psychological testing; extended outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management; outpatient treatment provided in your home; Applied Behavioral Analysis (ABA).
- Substance Use Disorder Services - inpatient services (including Partial Hospitalization/Day Treatment and services at a Residential Treatment Facility); intensive outpatient program treatment; psychological testing; outpatient treatment of opioid dependence; extended outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management; outpatient treatment provided in your home.

***Mental Health Services, Neurobiological Disorders - Autism Spectrum Disorder Services* and *Substance Use Disorder Services* in the *Certificate, Section 1: Covered Health Services* are deleted and replaced with the following:**

Mental Health Services

Mental Health Services include those received on an inpatient basis in a Hospital or an Alternate Facility, and those received on an outpatient basis in a provider's office or at an Alternate Facility.

Mental Health Services under this section include services for the following psychiatric illnesses (defined as Serious Mental Illness in Section 9: Defined Terms):

- Schizophrenia.
- Paranoid and other psychotic disorders.
- Bipolar disorders (hypomanic, manic, depressive, and mixed).
- Major depressive disorders (single episode or recurrent).
- Schizo-affective disorders (bipolar or depressive).
- Obsessive-compulsive disorders.
- Depression in childhood and adolescence.

Benefits for Mental Health Services include the following services provided on either an outpatient or inpatient basis:

- Diagnostic evaluations and assessment.
- Treatment planning.
- Referral services.
- Medication management.
- Individual, family, therapeutic group and provider-based case management services.
- Crisis intervention.

Benefits for Mental Health Services include the following services provided on an inpatient basis:

- Partial Hospitalization/Day Treatment Facility, including treatment in a Psychiatric Day Treatment Facility.
- Services at a Residential Treatment Facility.

Benefits for Mental Health Services include the following services provided on an outpatient basis:

- Intensive Outpatient Treatment.

Benefits are provided for alternative Mental Health Services for treatment of a Serious Mental Illness in a Residential Treatment Center for Children and Adolescents or from a Crisis Stabilization Unit, as required by State of Texas insurance law.

We determine coverage for all levels of care. If an Inpatient Stay is required, it is covered on a Semi-private Room basis.

We encourage you to contact us for referrals to providers and coordination of care.

Special Mental Health Programs and Services

Special programs and services that are contracted under us may become available to you as a part of your Mental Health Services Benefit. The Mental Health Services Benefits and financial requirements assigned to these programs or services are based on the designation of the program or service to inpatient, Partial Hospitalization/Day Treatment, Intensive Outpatient Treatment, outpatient or a Transitional Care category of Benefit use. Special programs or services provide access to services that are beneficial for the treatment of your Mental Illness which may not otherwise be covered under the Policy. You must be referred to such programs through us, and we are responsible for coordinating your care or through other pathways as described in the program introductions. Any decision to participate in such a program or service is at the discretion of the Covered Person and is not mandatory.

Neurobiological Disorders - Autism Spectrum Disorder Services

Psychiatric services for Autism Spectrum Disorders that are both of the following:

- Provided by or under the direction of an experienced psychiatrist and/or an experienced licensed psychiatric provider.
- Focused on treating maladaptive/stereotypic behaviors that are posing danger to self, others and property, and impairment in daily functioning.

This section describes only the psychiatric component of treatment for Autism Spectrum Disorders for which Benefits are not subject to any age limit.

Medical treatment of Autism Spectrum Disorders for an Enrolled Dependent child from the date of diagnosis until the child completes nine years of age is a Covered Health Service for which Benefits are available as described in the *Certificate* under *Autism Spectrum Disorders* in the section entitled *Additional Benefits Required By Texas Law*. Medical treatment of Autism Spectrum Disorders for all other Covered Persons is a Covered Health Service for which Benefits are available under the applicable medical Covered Health Services categories in the *Certificate*.

Benefits include the following services provided on either an outpatient or inpatient basis:

- Diagnostic evaluations and assessment.
- Treatment planning.
- Referral services.
- Medication management.
- Individual, family, therapeutic group and provider-based case management services.
- Crisis intervention.

Benefits include the following services provided on an inpatient basis:

- Partial Hospitalization/Day Treatment Facility, including treatment in a Psychiatric Day Treatment Facility.
- Services at a Residential Treatment Facility.

Benefits include the following services provided on an outpatient basis:

- Intensive Outpatient Treatment.

Enhanced Autism Spectrum Disorder services that are focused on educational/behavioral intervention that are habilitative in nature and that are backed by credible research demonstrating that the services or supplies have a measurable and beneficial health outcome. Benefits are provided for intensive behavioral therapies (educational/behavioral services that are focused on primarily building skills and capabilities in communication, social interaction and learning such as *Applied Behavioral Analysis (ABA)*).

We determine coverage for all levels of care. If an Inpatient Stay is required, it is covered on a Semi-private Room basis.

We encourage you to contact us for referrals to providers and coordination of care.

Substance Use Disorder Services

Substance Use Disorder Services include those received on an inpatient basis in a Hospital or an Alternate Facility, and those received on an outpatient basis in a provider's office or at an Alternate Facility. Substance Use Disorder Services include services for Chemical Dependency as required by Texas state law and/or regulation.

Benefits include the following services provided on either an outpatient or inpatient basis:

- Diagnostic evaluations and assessment.
- Treatment planning.
- Referral services.
- Medication management.
- Individual, family, therapeutic group and provider-based case management services.
- Crisis intervention.

Benefits include the following services provided on an inpatient basis:

- Partial Hospitalization/Day Treatment Facility, including treatment in a Psychiatric Day Treatment Facility.
- Services at a Residential Treatment Facility.

Benefits include the following services provided on an outpatient basis:

- Intensive Outpatient Treatment.

Benefits under this section include Chemical Dependency services as required under State of Texas insurance law and/or regulation. Benefits include detoxification from abusive chemicals or substances, limited to physical detoxification when necessary to protect your physical health and well-being. (Detoxification is the process of withdrawing a person from a specific psychoactive substance in a safe and effective manner.)

We determine coverage for all levels of care. If an Inpatient Stay is required, it is covered on a Semi-private Room basis.

We encourage you to contact us for referrals to providers and coordination of care.

Special Substance Use Disorder Programs and Services

Special programs and services that are contracted under us may become available to you as a part of your Substance Use Disorder Services Benefit. The Substance Use Disorder Services Benefits and financial requirements assigned to these programs or services are based on the designation of the program or service to inpatient, Partial Hospitalization/Day Treatment, Intensive Outpatient Treatment, outpatient or a Transitional Care category of Benefit use. Special programs or services provide access to services that are beneficial for the treatment of your substance use disorder which may not otherwise be covered under the Policy. You must be referred to such programs through us, and we are responsible for coordinating your care or through other pathways as described in the program introductions. Any decision to participate in such a program or service is at the discretion of the Covered Person and is not mandatory.

***Mental Health Services, Neurobiological Disorders - Autism Spectrum Disorder Services* and *Substance Use Disorder Services* in the *Schedule of Benefits* are deleted and replaced with the following:**

When Benefit limits apply, the limit refers to any combination of Network Benefits and Non-Network Benefits unless otherwise specifically stated.			
Covered Health Service	**Benefit (The Amount We Pay, based on Eligible Expenses)**	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
Mental Health Services (other than for treatment of Serious Mental Illness)			
Requests for Pre-authorization of Services For Non-Network Benefits for a scheduled admission for Mental Health Services (including an admission for Partial Hospitalization/Day Treatment and services at a Residential Treatment Facility), you must submit a request for pre-authorization of services to us prior to the admission, or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions). In addition, for Non-Network Benefits you must submit a request for pre-authorization of services to us before the following services are received, or as soon as reasonably possible: intensive outpatient program treatment; outpatient electro-convulsive treatment; psychological testing; extended outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management; outpatient treatment provided in your home. If you fail to submit a request for pre-authorization of services to us as required, Benefits will be reduced to 50% of Eligible Expenses, however the reduction of Benefits will not exceed $500.			
Treatment for Serious Mental Illness	***Network*** *Inpatient* 90% *Outpatient* 90% ***Non-Network*** *Inpatient* 70% *Outpatient* 70% ***Network*** *Inpatient* 90% *Outpatient*	Yes Yes Yes Yes Yes Yes	Yes Yes Yes Yes Yes Yes

When Benefit limits apply, the limit refers to any combination of Network Benefits and Non-Network Benefits unless otherwise specifically stated.			
Covered Health Service	**Benefit (The Amount We Pay, based on Eligible Expenses)**	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	90% ***Non-Network*** *Inpatient* 70% *Outpatient* 70%	Yes Yes Yes	Yes Yes Yes
Neurobiological Disorders - Autism Spectrum Disorder Services			
Requests for Pre-authorization of Services For Non-Network Benefits for a scheduled admission for Neurobiological Disorders - Autism Spectrum Disorder Services (including an admission for Partial Hospitalization/Day Treatment and services at a Residential Treatment Facility), you must submit a request for pre-authorization of services to us prior to the admission, or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions). In addition, for Non-Network Benefits you must submit a request for pre-authorization of services to us before the following services are received, or as soon as reasonably possible: intensive outpatient program treatment; psychological testing; extended outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management; outpatient treatment provided in your home; Applied Behavioral Analysis. If you fail to submit a request for pre-authorization of services to us as required, Benefits will be reduced to 50% of Eligible Expenses, however the reduction of Benefits will not exceed $500.			
	Network *Inpatient* 90% *Outpatient* 90% ***Non-Network*** *Inpatient* 70% *Outpatient* 70%	 Yes Yes Yes Yes	 Yes Yes Yes Yes
Substance Use Disorder Services (includes Chemical Dependency			

When Benefit limits apply, the limit refers to any combination of Network Benefits and Non-Network Benefits unless otherwise specifically stated.			
Covered Health Service	**Benefit (The Amount We Pay, based on Eligible Expenses)**	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
services as required under State of Texas insurance law and/or regulation)			
Requests for Pre-authorization of Services For Non-Network Benefits for a scheduled admission for Substance Use Disorder Services (including an admission for Partial Hospitalization/Day Treatment and services at a Residential Treatment Facility), you must submit a request for pre-authorization of services to us prior to the admission, or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions). In addition, for Non-Network Benefits you must submit a request for pre-authorization of services to us before the following services are received, or as soon as reasonably possible: intensive outpatient program treatment; psychological testing; outpatient treatment of opioid dependence; extended outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management; outpatient treatment provided in your home. If you fail to submit a request for pre-authorization of services to us as required, Benefits will be reduced to 50% of Eligible Expenses, however the reduction in Benefits will not exceed $500.			
	Network *Inpatient* 90% *Outpatient* 90% ***Non-Network*** *Inpatient* 70% *Outpatient* 70%	 Yes Yes Yes Yes	 Yes Yes Yes Yes

Exclusions for *Mental Health, Neurobiological Disorders - Autism Spectrum Disorders* and *Substance Use Disorders* in the *Certificate* under *Section 2: Exclusions and Limitations* are deleted and replaced with the following:

Mental Health

Exclusions listed directly below apply to services described under *Mental Health Services* in *Section 1: Covered Health Services*.

1. Services performed in connection with conditions not classified in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.

2. Mental Health Services as treatments for V-code conditions as listed within the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.

3. Mental Health Services as treatment for a primary diagnosis of insomnia and other sleep disorders, sexual dysfunction disorders, feeding disorders, neurological disorders and other disorders with a known physical basis.

4. Treatments for the primary diagnoses of learning disabilities, conduct and impulse control disorders, personality disorders and paraphilias.

5. Educational/behavioral services that are focused on primarily building skills and capabilities in communication, social interaction and learning.

6. Tuition for or services that are school-based for children and adolescents under the *Individuals with Disabilities Education Act*.

7. Learning, motor skills and primary communication disorders as defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.

8. Mental retardation and autism spectrum disorder as a primary diagnosis defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*. **Please Note:** This Mental Health exclusion section excludes Autism Spectrum Disorders because treatment for Autism Spectrum Disorders are not covered/provided under the Mental Health Services Benefit section of *Section 1: Covered Health Services*. Instead, Benefits for autism spectrum disorder as a primary diagnosis are covered/provided under *Neurobiological Disorders - Autism Spectrum Disorder Services* in *Section 1: Covered Health Services*.

9. Services or supplies for the diagnosis or treatment of Mental Illness that, in our reasonable judgment, are any of the following:

   - Not consistent with generally accepted standards of medical practice for the treatment of such conditions.
   - Not consistent with services backed by credible research soundly demonstrating that the services or supplies will have a measurable and beneficial health outcome, and therefore considered experimental.
   - Not consistent with our level of care guidelines or best practices as modified from time to time.
   - Not clinically appropriate for the patient's Mental Illness or condition based on generally accepted standards of medical practice and benchmarks.

Neurobiological Disorders - Autism Spectrum Disorders

Exclusions listed directly below apply to services described under *Neurobiological Disorders - Autism Spectrum Disorder Services* in *Section 1: Covered Health Services*.

1. Services as treatments of sexual dysfunction and feeding disorders as listed in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.

2. Any treatments or other specialized services designed for Autism Spectrum Disorder that are not backed by credible research demonstrating that the services or supplies have a measurable and beneficial health outcome and therefore considered Experimental or Investigational or Unproven Services.

3. Mental retardation as the primary diagnosis defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.

4. Tuition for or services that are school-based for children and adolescents under the *Individuals with Disabilities Education Act*.

5. Services as treatment of learning, motor skills and primary communication disorders as defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association* which are not a part of an Autism Spectrum Disorder.

6. Services or supplies for the diagnosis or treatment of Mental Illness that, in our reasonable judgment, are any of the following:

   - Not consistent with generally accepted standards of medical practice for the treatment of such conditions.
   - Not consistent with services backed by credible research soundly demonstrating that the services or supplies will have a measurable and beneficial health outcome, and therefore considered experimental.
   - Not consistent with our level of care guidelines or best practices as modified from time to time.
   - Not clinically appropriate for the patient's Mental Illness or condition based on generally accepted standards of medical practice and benchmarks.

Substance Use Disorders

Exclusions listed directly below apply to services described under *Substance Use Disorder Services* in *Section 1: Covered Health Services*.

1. Services performed in connection with conditions not classified in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.

2. Methadone treatment as maintenance, L.A.A.M. (1-Alpha-Acetyl-Methadol), Cyclazocine, or their equivalents.

3. Educational/behavioral services that are focused on primarily building skills and capabilities in communication, social interaction and learning.

4. Services or supplies for the diagnosis or treatment of alcoholism or substance use disorders that, in our reasonable judgment are any of the following:

   - Not consistent with generally accepted standards of medical practice for the treatment of such conditions.
   - Not consistent with services backed by credible research soundly demonstrating that the services or supplies will have a measurable and beneficial health outcome, and therefore considered experimental.
   - Not consistent with our level of care guidelines or best practices as modified from time to time.
   - Not clinically appropriate for the patient's substance use disorder or condition based on generally accepted standards of medical practice and benchmarks.

The definition of Intermediate Care is deleted.

UNITEDHEALTHCARE INSURANCE COMPANY

Jeffrey Alter, President

Patient Protection and Affordable Care Act (PPACA) Amendment

UnitedHealthcare Insurance Company

As described in this Amendment, the Policy is modified as stated below.

Because this Amendment is part of a legal document (the group Policy), we want to give you information about the document that will help you understand it. Certain capitalized words have special meanings. We have defined these words in the *Certificate of Coverage (Certificate)* in *Section 9: Defined Terms* and in this Amendment below.

Maximum Policy Benefit/Limits on Essential Benefits

The Maximum Policy Benefit provision in the *Schedule of Benefits*, the definition of Maximum Policy Benefit in the *Certificate* and all references to a Maximum Policy Benefit are deleted. Benefits under the Policy are not limited by a Maximum Policy Benefit.

Lifetime limits on the dollar amount of essential benefits available to you under the terms of your plan are no longer permitted. In addition, any annual dollar limit applicable to the essential benefits listed below is no longer applicable. Essential benefits include the following:

> Ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services (including behavioral health treatment); prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

On or before the first day of the first plan year beginning on or after September 23, 2010, the Enrolling Group will provide a 30 day enrollment period for those individuals who are still eligible under the plan's eligibility terms but whose coverage ended by reason of reaching a lifetime limit on the dollar value of all Benefits.

Preventive Care

Network Benefits for preventive care that are payable at 100% of Eligible Expenses (without application of any Copayment, Coinsurance, or deductible) apply to the following:

- Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the *United States Preventive Services Task Force*.
- Immunizations that have in effect a recommendation from the *Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention*.
- With respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the *Health Resources and Services Administration*.
- With respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the *Health Resources and Services Administration*.
- Samples of preventive care services include:
  - Blood pressure, diabetes and cholesterol tests.

- Many cancer screenings, including mammograms and colonoscopies.
- Counseling on such topics as quitting smoking, losing weight, eating healthy foods, reducing alcohol use.
- Routine vaccinations against diseases such as measles, polio or meningitis, flu and pneumonia.
- Regular well-baby and well-child visits.

Please contact us at the telephone number on the back of your ID card if you have any questions or you need assistance with determining whether a service is eligible for coverage as a preventive service.

For a comprehensive list of recommended preventive services, go to www.healthcare.gov/center/regulation/prevention.html.

Preexisting Conditions

Preexisting condition exclusions do not apply to Covered Persons under age 19. The preexisting condition exclusion in the *Certificate, Section 2: Exclusions and Limitations* is replaced with the following:

Preexisting Conditions

1. Benefits for the treatment of a Preexisting Condition are excluded until the date you have had Continuous Creditable Coverage for 12 months. This exclusion does not apply to Covered Persons under age 19.

Dependent Children

The following *Dependent Child Special Open Enrollment* provision is added to the *Certificate, Section 3: When Coverage Begins*:

Dependent Child Special Open Enrollment Period

On or before the first day of the first plan year beginning on or after September 23, 2010, the Enrolling Group will provide a 30 day dependent child special open enrollment period for Dependent children who are not currently enrolled under the Policy and who have not yet reached the limiting age. During this dependent child special open enrollment period, Subscribers who are adding a Dependent child and who have a choice of coverage options will be allowed to change options.

Coverage begins on the first day of the plan year beginning on or after September 23, 2010, if we receive the completed enrollment form and any required Premium within 31 days of the date the Dependent becomes eligible to enroll under this special open enrollment period.

The definition of Dependent is replaced with the following:

Dependent - the Subscriber's legal spouse, including a common law spouse, or a child of the Subscriber or the Subscriber's spouse. All references to the spouse of a Subscriber shall include a Domestic Partner. The term child includes any of the following:

- A natural child.
- A stepchild.
- A legally adopted child.
- A child placed for adoption.
- A child for whom the Subscriber is a party in suit seeking adoption.

- A child for whom legal guardianship has been awarded to the Subscriber or the Subscriber's spouse.

The marital status or lack of marital status between the Subscriber and the other parent will not be a factor in determining a Dependent's eligibility.

The definition of Dependent is subject to the following conditions and limitations:

- A Dependent includes any child listed above under 26 years of age.
- A Dependent includes an unmarried dependent child age 26 or older who is or becomes disabled and dependent upon the Subscriber.
- A Dependent includes a grandchild of the Subscriber, who is under 26 years of age and is a Dependent of the Subscriber for federal income tax purposes at the time the application for coverage of the grandchild is made.

The Subscriber must reimburse us for any Benefits that we pay for a child at a time when the child did not satisfy these conditions.

A Dependent also includes a child for whom health care coverage is required through a *Qualified Medical Child Support Order* or other court or administrative order issued by a judge by a court that has jurisdiction over the matter and meets the criteria of a *Qualified Medical Child Support Order*.

A Dependent does not include anyone who is also enrolled as a Subscriber. No one can be a Dependent of more than one Subscriber.

Fraud or Intentional Misrepresentation of a Material Fact

The terminating provision for *Fraud, Misrepresentation or False Information* in the *Certificate, Section 4: When Coverage Ends* is replaced with the following:

- **Fraud or Intentional Misrepresentation of a Material Fact**

  You committed an act, practice, or omission that constituted fraud, or an intentional misrepresentation of a material fact. Examples include false information relating to another person's eligibility or status as a Dependent.

  During the first two years the Policy is in effect, we have the right to require that you pay back all Benefits we paid to you, or paid in your name, during the time you were incorrectly covered under the Policy. After the first two years, we cannot require that you pay back Benefits due to fraud or an intentional misrepresentation of a material fact, unless the statement is contained in a written instrument signed by the individual making the statement.

  If your coverage ends for this reason, we will provide you at least 30 days advance written notice.

Claims and Appeals

In addition to the processes and procedures described in *Section 6: Questions, Complaints and Appeals,* other changes provided for under the *PPACA* impact how claims and appeals are handled and are applicable to your plan:

- You have the right to an appeal process.
- If any new or additional evidence is relied upon or generated by us during the determination of an appeal we will provide it to you free of charge and sufficiently in advance of the due date of the response to the adverse benefit determination.
- With respect to any urgent request for Benefits you will receive the notice of benefit determination within 24 hours after we have received all necessary information.

Other changes provided for under the *PPACA*:

Other changes provided for under the *PPACA* do not impact your plan because your plan already contains these provisions. These include:

- Direct access to OB/GYN care without a referral or authorization requirement.
- The ability to designate a pediatrician as a primary care physician (PCP) if your plan requires a PCP designation.
- The ability to designate any primary care physician (PCP) that is accepting new patients.
- Prior authorization is not required before you receive services in the emergency department of a Hospital.
- If you seek emergency care services from non-Network providers in the emergency department of a Hospital or in a Freestanding Emergency Medical Care Facility, your cost sharing obligations (Copayments and/or Coinsurance) will be the same as would be applied to emergency care services received from Network providers.

UNITEDHEALTHCARE INSURANCE COMPANY

Jeffrey Alter, President

Discretionary Clause Amendment

UnitedHealthcare Insurance Company

As described in this Amendment, the Policy is modified to remove discretionary clause provisions.

Because this Amendment is part of a legal document (the group Policy), we want to give you information about the document that will help you understand it. Certain capitalized words have special meanings. We have defined these words in the *Certificate of Coverage (Certificate)* in *Section 9: Defined Terms* and in this Amendment below.

1. *Determine Benefits* and *Review and Determine Benefits in Accordance with our Reimbursement Policies* in the *Certificate,* under *Our Responsibilities Section* are replaced with the following:

Determine Benefits

We make administrative decisions regarding whether this Benefit plan will pay for any portion of the cost of a health care service you intend to receive or have received. Our decisions are for payment purposes only. We do not make decisions about the kind of care you should or should not receive. You and your providers must make those treatment decisions.

We have the ability to do the following:

- Interpret Benefits and the other terms, limitations and exclusions set out in this *Certificate*, the *Schedule of Benefits*, and any Riders and/or Amendments.
- Make factual determinations relating to Benefits.

We may delegate this authority to other persons or entities that may provide administrative services for this Benefit plan, such as claims processing. The identity of the service providers and the nature of their services may be changed from time to time. In order to receive Benefits, you must cooperate with those service providers.

Review and Determine Benefits in Accordance with our Reimbursement Policies

We develop our reimbursement policy guidelines in accordance with one or more of the following methodologies:

- As indicated in the most recent edition of the *Current Procedural Terminology (CPT)*, a publication of the *American Medical Association*, and/or the *Centers for Medicare and Medicaid Services (CMS)*.
- As reported by generally recognized professionals or publications.
- As used for Medicare.
- As determined by medical staff and outside medical consultants pursuant to other appropriate sources or determinations that we accept.

Following evaluation and validation of certain provider billings (e.g., error, abuse and fraud reviews), our reimbursement policies are applied to provider billings. We share our reimbursement policies with Physicians and other providers in our Network through our provider website. Network Physicians and providers may not bill you for the difference between their contract rate (as may be modified by our reimbursement policies) and the billed charge. However, non-Network providers are not subject to this prohibition, and may bill you for any amounts we do not pay, including amounts that are denied because one of our reimbursement policies does not reimburse (in whole or in part) for the service billed. You may

obtain copies of our reimbursement policies for yourself or to share with your non-Network Physician or provider by going to www.myuhc.com or by calling *Customer Care* at the telephone number on your ID card.

2. The exclusion for Travel in the *Certificate* under *Section 2: Exclusions and Limitations, Travel* is replaced with the following:

Travel

1. Health services provided in a foreign country, unless required as Emergency Health Services.
2. Travel or transportation expenses, even though prescribed by a Physician. Some travel expenses related to Covered Health Services received from a Designated Facility or Designated Physician may be reimbursed.
3. The provision in the *Certificate* under *Section 5: How to File a Claim, If You Receive Covered Health Services from a Non-Network Provider* is replaced with the following:

If You Receive Covered Health Services from a Non-Network Provider

When you receive Covered Health Services from a non-Network provider, you are responsible for requesting payment from us. You must file the claim in a format that contains all of the information we require, as described below.

You should submit a request for payment of Benefits within 90 days after the date of service. If you don't provide this information to us within 15 months of the date of service, Benefits for that health service will be denied or reduced. This time limit does not apply if you are legally incapacitated. If your claim relates to an Inpatient Stay, the date of service is the date your Inpatient Stay ends.

4. The provision in the *Certificate* under *Section 8: General Legal Provisions, Interpretation of Benefits, Administrative Services* and *Amendments to the Policy* are replaced with the following:

Interpretation of Benefits

We will, in accordance with state and federal law, do all of the following:

- Interpret Benefits under the Policy.
- Interpret the other terms, conditions, limitations and exclusions set out in the Policy, including this *Certificate*, the *Schedule of Benefits*, and any Riders and/or Amendments.
- Make factual determinations related to the Policy and its Benefits.

We may delegate this authority to other persons or entities that provide services in regard to the administration of the Policy.

In certain circumstances, for purposes of overall cost savings or efficiency, we may offer Benefits for services that would otherwise not be Covered Health Services. The fact that we do so in any particular case shall not in any way be deemed to require us to do so in other similar cases.

Administrative Services

We may arrange for various persons or entities to provide administrative services in regard to the Policy, such as claims processing. The identity of the service providers and the nature of the services they provide may be changed from time to time. We are not required to give you prior notice of any such change, nor are we required to obtain your approval. You must cooperate with those persons or entities in the performance of their responsibilities.

Amendments to the Policy

To the extent permitted by law we reserve the right, without your approval, to change, interpret, modify, withdraw or add Benefits or terminate the Policy.

Any provision of the Policy which, on its effective date, is in conflict with the requirements of state or federal statutes or regulations (of the jurisdiction in which the Policy is delivered) is hereby amended to conform to the minimum requirements of such statutes and regulations.

No other change may be made to the Policy unless it is made by an Amendment or Rider which has been signed by one of our officers. All of the following conditions apply:

- Amendments to the Policy are effective 31 days after we send written notice to the Enrolling Group.
- Riders are effective on the date we specify.
- No agent has the authority to change the Policy or to waive any of its provisions.
- No one has authority to make any oral changes or amendments to the Policy.

5. The definition of Eligible Expenses, Experimental or Investigational Service(s) and Unproven Service(s) in the *Certificate* under *Section 9: Defined Terms* are replaced with the following:

Eligible Expenses - for Covered Health Services, incurred while the Policy is in effect, Eligible Expenses are determined by us as stated below and as detailed in the *Schedule of Benefits*.

Eligible Expenses are determined solely in accordance with our reimbursement policy guidelines. We develop our reimbursement policy guidelines following evaluation and validation of all provider billings in accordance with one or more of the following methodologies:

- As indicated in the most recent edition of the *Current Procedural Terminology (CPT)*, a publication of the *American Medical Association*, and/or the *Centers for Medicare and Medicaid Services (CMS)*.
- As reported by generally recognized professionals or publications.
- As used for Medicare.
- As determined by medical staff and outside medical consultants pursuant to other appropriate source or determination that we accept.

Experimental or Investigational Service(s) - medical, surgical, diagnostic, psychiatric, mental health, substance use disorders or other health care services, technologies, supplies, treatments, procedures, drug therapies, medications or devices that, at the time we make a determination regarding coverage in a particular case, are determined to be any of the following:

- Not approved by the *U.S. Food and Drug Administration (FDA)* to be lawfully marketed for the proposed use and not identified in the *American Hospital Formulary Service* or the *United States Pharmacopoeia Dispensing Information* as appropriate for the proposed use.
- Subject to review and approval by any institutional review board for the proposed use. (Devices which are *FDA* approved under the *Humanitarian Use Device* exemption are not considered to be Experimental or Investigational.)
- The subject of an ongoing clinical trial that meets the definition of a Phase 1, 2, 3 or 4 clinical trial set forth in the *FDA* regulations, regardless of whether the trial is actually subject to *FDA* oversight.

Exceptions:

- These criteria shall not apply for drugs prescribed to treat a chronic, disabling, or life-threatening illness if the drug is both of the following:

- Has been approved by the *FDA* for at least one indication.
- Is recognized for treatment of the indication for which the drug is prescribed in either of the following:
  - A prescription drug reference compendium approved by the Commissioner of the *Texas Department of Insurance*.
  - Substantially accepted peer-reviewed medical literature.

- Clinical trials for which Benefits are available as described under *Clinical Trials* in *Section 1: Covered Health Services.*
- Life-Threatening Sickness or Condition. If you have a life-threatening Sickness or condition (one that is likely to cause death within one year of the request for treatment) we may consider an otherwise Experimental or Investigational Service to be a Covered Health Service for that Sickness or condition. Prior to such a consideration, we must first establish that there is sufficient evidence to conclude that, albeit unproven, the service has significant potential as an effective treatment for that Sickness or condition, and that the service would be provided under standards equivalent to those defined by the *National Institutes of Health*.

Unproven Service(s) - services, including medications, that are determined not to be effective for treatment of the medical condition and/or not to have a beneficial effect on health outcomes due to insufficient and inadequate clinical evidence from well-conducted randomized controlled trials or cohort studies in the prevailing published peer-reviewed medical literature.

- Well-conducted randomized controlled trials. (Two or more treatments are compared to each other, and the patient is not allowed to choose which treatment is received.)
- Well-conducted cohort studies. (Patients who receive study treatment are compared to a group of patients who receive standard therapy. The comparison group must be nearly identical to the study treatment group.)

We have a process by which we compile and review clinical evidence with respect to certain health services. From time to time, we issue medical and drug policies that describe the clinical evidence available with respect to specific health care services. These medical and drug policies are subject to change without prior notice. You can view these policies at www.myuhc.com.

Please note:

- If you have a life-threatening Sickness or condition (one that is likely to cause death within one year of the request for treatment) we may consider an otherwise Unproven Service to be a Covered Health Service for that Sickness or condition. Prior to such a consideration, we must first establish that there is sufficient evidence to conclude that, albeit unproven, the service has significant potential as an effective treatment for that Sickness or condition, and that the service would be provided under standards equivalent to those defined by the *National Institutes of Health*.
- We may consider an otherwise Unproven Service to be a Covered Health Service for a Covered Person with a Sickness or Injury that is not life-threatening. For that to occur, all of the following conditions must be met:
  - If the service is one that requires review by the *U.S. Food and Drug Administration (FDA)*, it must be *FDA*-approved.
  - It must be performed by a Physician and in a facility with demonstrated experience and expertise.
  - The Covered Person must consent to the procedure acknowledging that we do not believe that sufficient clinical evidence has been published in peer-reviewed medical literature to conclude that the service is safe and/or effective.

- At least two studies must be available in published peer-reviewed medical literature that would allow us to conclude that the service is promising but unproven.
- The service must be available from a Network Physician and/or a Network facility.

We will determine whether such a service can be deemed a Covered Health Service. Other apparently similar promising but unproven services may not qualify.

Prescription drugs prescribed to treat a chronic, disabling or life-threatening illness are covered services if the drug is both of the following:

- Has been approved by the *U.S. Food and Drug Administration (FDA)* for at least one indication.
- Is recognized for treatment of the indication for which the drug is prescribed in either of the following:
  - A prescription drug reference compendium approved by the Commissioner of the *Texas Department of Insurance*.
  - Substantially accepted peer-reviewed medical literature.

6. *Designated Facilities and Other Providers* in the *Schedule of Benefits* is replaced with the provision below:

Designated Facilities and Other Providers

If you have a medical condition that we believe needs special services, we may direct you to a Designated Facility or Designated Physician chosen by us. If you require certain complex Covered Health Services for which expertise is limited, we may direct you to a Network facility or provider that is outside your local geographic area. If you are required to travel to obtain such Covered Health Services from a Designated Facility or Designated Physician, we may reimburse certain travel expenses.

You or your Network Physician must submit a Request for pre-authorization of services to us of special service needs (such as transplants or cancer treatment) that might warrant referral to a Designated Facility or Designated Physician. If you do not submit a Request for pre-authorization of services to us in advance, and if you receive services from a non-Network facility (regardless of whether it is a Designated Facility) or other non-Network provider, Network Benefits will be reduced to 50% of Eligible Expenses, however the reduction in Benefits will not exceed $500. Non-Network Benefits will be available if the special needs services you receive are Covered Health Services for which Benefits are provided under the Policy.

UNITEDHEALTHCARE INSURANCE COMPANY

Jeffrey Alter, President

Questions, Complaints and Appeals Amendment

UnitedHealthcare Insurance Company

Because this Amendment reflects changes in requirements of Federal and Texas law, to the extent it may conflict with any Amendment issued to you previously, the provisions of this Amendment will govern.

As described in this Amendment, the Policy is modified by replacing *Section 6: Questions, Complaints and Appeals* of the *Certificate of Coverage* with the provision below.

Section 6: Questions, Complaints and Appeals

To resolve a question, complaint, or appeal, just follow these steps:

What to Do if You Have a Question

Contact *Customer Care* at the telephone number shown on your ID card. *Customer Care* representatives are available to take your call during regular business hours, Monday through Friday.

What to Do if You Have a Complaint

Contact *Customer Care* at the telephone number shown on your ID card. *Customer Care* representatives are available to take your call during regular business hours, Monday through Friday.

If you would rather send your complaint to us in writing, the *Customer Care* representative can provide you with the appropriate address.

If the *Customer Care* representative cannot resolve the issue to your satisfaction over the telephone, he/she can help you prepare and submit a written complaint.

We shall promptly investigate each complaint. The total time for acknowledgement, investigation and resolution of the complaint shall not exceed 30 calendar days after we receive the written complaint or the one-page complaint form.

Complaints concerning presently occurring Emergencies or denials of continued stays for hospitalization shall be investigated and resolved in accordance with the medical immediacy, and shall not exceed one business day from receipt of the complaint.

We shall not engage in any retaliatory action against any Covered Person. We shall not retaliate for any reason including, for example, cancellation of coverage or refusal to renew coverage because the Covered Person or person acting on behalf of the Covered Person has filed a complaint against the Policy or has appealed a decision.

How to Appeal a Claim Decision

Post-service Claims

Post-service claims are those claims that are filed for payment of Benefits after medical care has been received.

Pre-service Requests for Benefits

Pre-service requests for Benefits are those requests that require prior notification or benefit confirmation prior to receiving medical care.

How to Request an Appeal

If you disagree with either a pre-service request for Benefits determination, post-service claim determination or a rescission of coverage determination, you can contact us in writing to formally request an appeal. If your appeal relates to a non-clinical denial, refer to *How to Appeal a Non-clinical Benefit Determination* below.

Your request for an appeal should include:

- The patient's name and the identification number from the ID card.
- The date(s) of medical service(s).
- The provider's name.
- The reason you believe the claim should be paid.
- Any documentation or other written information to support your request for claim payment.

Please note that our decision is based only on whether or not Benefits are available under the Policy for the proposed treatment or procedure. The decision for you to receive services is between you and your Physician.

Your first appeal request must be submitted to us within 180 days after you receive the denial of a pre-service request for Benefits or the claim denial.

Prior Authorization of Services

A request for prior authorization of services is a notification to us of proposed services that will result in one of the following:

- A Pre-authorization;
- An Adverse Determination; or
- When there are no clinical issues for us to determine, a confirmation of receipt of your request.

If you receive an Adverse Determination, as described above, in response to your request for prior authorization of services, you may appeal the decision. Please refer to *How to Appeal an Adverse Determination* below. If you receive a pre-service Non-clinical Benefit Determination from us in response to your request for prior authorization of services, you may appeal our decision. Please refer to *How to Appeal a Non-clinical Benefit Determination* below.

For procedures associated with urgent requests for prior authorization of services, see *Urgent Appeals that Require Immediate Action* below.

Appeal Process

A qualified individual who was not involved in the decision being appealed will be appointed to decide the appeal. If your appeal is related to clinical matters, the review will be done in consultation with a health care professional with appropriate expertise in the field, who was not involved in the prior determination. We may consult with, or seek the participation of, medical experts as part of the appeal resolution process. You consent to this referral and the sharing of pertinent medical claim information. Upon request and free of charge, you have the right to reasonable access to and copies of all documents, records and

other information relevant to your claim for Benefits. In addition, if any new or additional evidence is relied upon or generated by us during the determination of the appeal, we will provide it to you free of charge and sufficiently in advance of the due date of the response to the adverse benefit determination.

Appeals Determinations

Pre-service Requests for Benefits and Post-service Claim Appeals

For procedures associated with urgent requests for Benefits, see *Urgent Appeals that Require Immediate Action* below.

You will be provided written or electronic notification of the decision on your appeal as follows:

- For appeals of pre-service requests for Benefits as identified above, the appeal will be conducted and you will be notified of the decision within 30 days from receipt of a request for appeal of a denied request for Benefits.
- For appeals of post-service claims as identified above, the appeal will be conducted and you will be notified of the decision within 60 days from receipt of a request for appeal of a denied claim.

Please note that our decision is based only on whether or not Benefits are available under the Policy for the proposed treatment or procedure. We don't determine whether the pending health service is necessary or appropriate. That decision is between you and your Physician.

You may have the right to external review through an *Independent Review Organization (IRO)* upon the completion of the internal appeal process. Instructions regarding any such rights, and how to access those rights, will be provided in our decision letter to you.

How to Appeal an Adverse Determination

If you receive an Adverse Determination in response to a claim or a request for prior authorization of services, you, a person acting on your behalf, or your Physician or health care provider can contact us orally or in writing to formally request a clinical appeal.

Your request for an Adverse Determination appeal should include:

- The patient's name and the identification number from the ID card.
- The date(s) of medical service(s).
- The provider's name.
- The reason you believe the claim should be paid.
- Any documentation or other written information to support your request for claim payment.

Upon receipt of your appeal we will, within five working days, send you a letter acknowledging receipt of your appeal and provide you with a description of the Adverse Determination appeal process and a list of documents necessary to process your appeal.

Our review will be done in consultation with a health care professional with appropriate expertise in the field, who was not involved in the prior determination. We may consult with, or seek the participation of, medical experts as part of the appeal resolution process. You consent to this referral and the sharing of pertinent medical claim information. Upon request and free of charge, you have the right to reasonable access to and copies of all documents, records and other information relevant to your claim for Benefits. In addition, if any new or additional evidence is relied upon or generated by us during the determination of the appeal, we will provide it to you free of charge and sufficiently in advance of the due date of the response to the adverse benefit determination.

Retrospective Review

If the Adverse Determination relates to a retrospective review, you will receive notice no later than 30 days after we receive your claim. We may extend this period for up to an additional 15 days if we determine an extension is necessary due to matters beyond our control. If an extension is needed, you will be notified within 30 days after we receive your claim. If the extension is necessary because we have not received information from you or your provider, we will specifically describe the information needed and allow 45 days for the information to be submitted. We will make a decision within 30 days of the date of the extension notice until the earlier of the date you or your provider respond to the request for additional information or the date the information was to be submitted.

Denied Appeals Specialty Provider Review

If we uphold the clinical appeal, your provider may, within 10 working days of the appeal denial, request a review by a specialty provider by submitting a written request showing good cause for the additional review.

Denied Appeals - Independent Review Organization

If all of the following apply, you may request a review of a clinical benefit determination or an Adverse Determination by an *Independent Review Organization*:

- Your complaint relates to a clinical benefit determination or an Adverse Determination.
- The clinical benefit determination or Adverse Determination is upheld.
- You have exhausted the clinical appeal procedure as described above.

If the determination is to uphold the Adverse Determination, the written notice will include the clinical basis for the determination, the specialty of the Physician making the decision, and your right to appeal the decision.

If a complaint relates to a life-threatening condition or an urgent care situation or if we have failed to meet the internal appeal process timeframes stated above, you may request an immediate review by an *Independent Review Organization* without exhausting the above described procedures.

Expedited external review of urgent care claims is available in that the IRO is required to inform us and the claimant of an urgent care decision within four business days or less from the receipt of the request for review. If the IRO decision is given orally, the IRO is required to provide written notice of its decision within 48 hours of the oral notification.

We will pay for the costs relating to this review and will comply with the decision. You may request a review by an *Independent Review Organization* without exhausting the appeal procedure if the Adverse Determination relates to a life-threatening condition or an urgent care situation.

Urgent Appeals that Require Immediate Action

Your appeal may require immediate action if a delay in treatment could significantly increase the risk to your health, or the ability to regain maximum function, or cause severe pain. In these urgent situations:

- The appeal does not need to be submitted in writing. You or your Physician should call us as soon as possible.
- We will notify you of the decision by the end of the next business day following receipt of your request for review of the determination, taking into account the seriousness of your condition.
- If we need more information from your Physician to make a decision, we will notify you of the decision by the end of the next business day following receipt of the required information.

- The appeal process for urgent situations does not apply to prescheduled treatments, therapies or surgeries.
- If you are not satisfied with our decision, you have the right to take your complaint to the *Texas Department of Insurance*.

How to Appeal a Non-clinical Benefit Determination

If you receive a benefit denial in response to a request for prior authorization of services or as a result of a post service claim determination, you, a person acting on your behalf, or your Physician or health care provider can contact us orally or in writing to formally request an appeal.

Your request for appeal should include:

- The patient's name and the identification number from the ID card.
- The date(s) of medical service(s).
- The provider's name.
- The reason you believe the claim should be paid.
- Any documentation or other written information to support your request for claim payment.

Non-clinical Benefit Determination is a determination made by us that proposed or delivered services are or are not covered services according to the terms of the insurance policy without reference to the medical necessity or appropriateness of the services. A Non-clinical Benefit Determination that services are not covered is not an Adverse Determination.

For appeals of Non-clinical Benefit Determinations and post service claims as identified above, the first level appeal will be conducted and you will be notified of the decision within 30 days from receipt of a request for appeal of a denied claim. If you are not satisfied with the first level appeal decision, you have the right to request a second level appeal. The second level appeal will be conducted and you will be notified of the decision within 30 days from receipt of a request for review of the first level appeal decision.

UNITEDHEALTHCARE INSURANCE COMPANY

Jeffrey Alter, President

Outpatient Prescription Drug

UnitedHealthcare Insurance Company

Schedule of Benefits

Benefits for Prescription Drug Products

Benefits are available for Prescription Drug Products at either a Network Pharmacy or a non-Network Pharmacy and are subject to Copayments and/or Coinsurance or other payments that vary depending on which of the tiers of the Prescription Drug List the Prescription Drug Product is listed.

Benefits for Prescription Drug Products are available when the Prescription Drug Product meets the definition of a Covered Health Service or is prescribed to prevent conception.

Supply Limits

Benefits for Prescription Drug Products are subject to the supply limits that are stated in the "Description and Supply Limits" column of the Benefit Information table. For a single Copayment and/or Coinsurance, you may receive a Prescription Drug Product up to the stated supply limit.

Note: Some products are subject to additional supply limits based on criteria that we have developed, subject to our periodic review and modification. The limit may restrict the amount dispensed per Prescription Order or Refill and/or the amount dispensed per month's supply.

You may determine whether a Prescription Drug Product has been assigned a supply limit for dispensing through the Internet at www.myuhc.com or by calling *Customer Care* at the telephone number on your ID card.

Request for Pre-authorization of Services Requirements

Before certain Prescription Drug Products are dispensed to you, either your Physician, your pharmacist or you are required to submit a Request for pre-authorization of services to us or our designee. The reason for submitting a Request for pre-authorization of services to us is to determine whether the Prescription Drug Product, in accordance with our approved guidelines, is each of the following:

- It meets the definition of a Covered Health Service.
- It is not an Experimental or Investigational or Unproven Service.

Network Pharmacy Request for Pre-authorization of Services

When Prescription Drug Products are dispensed at a Network Pharmacy, the prescribing provider, the pharmacist, or you are responsible for submitting a Request for pre-authorization of services to us.

Non-Network Pharmacy Request for Pre-authorization of Services

When Prescription Drug Products are dispensed at a non-Network Pharmacy, you or your Physician are responsible for submitting a Request for pre-authorization of services to us as required.

If we did not receive a Request for pre-authorization of services before the Prescription Drug Product is dispensed, you may pay more for that Prescription Order or Refill. The Prescription Drug Products

requiring a Request for pre-authorization of services are subject to our periodic review and modification. You may determine whether a particular Prescription Drug Product requires a Request for pre-authorization of services through the Internet at www.myuhc.com or by calling *Customer Care* at the telephone number on your ID card.

If we did not receive a Request for pre-authorization of services before certain Prescription Drug Products are dispensed, you can ask us to consider reimbursement after you receive the Prescription Drug Product. You will be required to pay for the Prescription Drug Product at the pharmacy. Our contracted pharmacy reimbursement rates (our Prescription Drug Cost) will not be available to you at a non-Network Pharmacy. You may seek reimbursement from us as described in the *Certificate of Coverage (Certificate)* in *Section 5: How to File a Claim*.

When you submit a claim on this basis, you may pay more because you did not submit a Request for pre-authorization of services to us before the Prescription Drug Product was dispensed. The amount you are reimbursed will be based on the Prescription Drug Cost (for Prescription Drug Products from a Network Pharmacy) or the Predominant Reimbursement Rate (for Prescription Drug Products from a non-Network Pharmacy), less the required Copayment and/or Coinsurance and any deductible that applies.

Benefits may not be available for the Prescription Drug Product after we review the documentation provided and we determine that the Prescription Drug Product is not a Covered Health Service or it is an Experimental or Investigational or Unproven Service.

Step Therapy

Certain Prescription Drug Products for which Benefits are described under this Prescription Drug Rider or Pharmaceutical Products for which Benefits are described in your *Certificate* are subject to step therapy requirements. This means that in order to receive Benefits for such Prescription Drug Products or Pharmaceutical Products you are required to use a different Prescription Drug Product(s) or Pharmaceutical Product(s) first.

You may determine whether a particular Prescription Drug Product or Pharmaceutical Product is subject to step therapy requirements through the Internet at www.myuhc.com or by calling *Customer Care* at the telephone number on your ID card.

What You Must Pay

You are responsible for paying the Annual Deductible stated in the *Schedule of Benefits* which is attached to your *Certificate* before Benefits for Prescription Drug Products under this Rider are available to you.

You are responsible for paying the applicable Copayment and/or Coinsurance described in the Benefit Information table.

The amount you pay for any of the following under this Rider will not be included in calculating any Out-of-Pocket Maximum stated in your *Certificate*:

- Any non-covered drug product. You are responsible for paying 100% of the cost (the amount the pharmacy charges you) for any non-covered drug product and our contracted rates (our Prescription Drug Cost) will not be available to you.

Payment Information

Payment Term And Description	Amounts
Copayment and Coinsurance	
Copayment Copayment for a Prescription Drug Product at a Network or non-Network Pharmacy is a specific dollar amount. ***Coinsurance*** Coinsurance for a Prescription Drug Product at a Network Pharmacy is a percentage of the Prescription Drug Cost. Coinsurance for a Prescription Drug Product at a non-Network Pharmacy is a percentage of the Predominant Reimbursement Rate. ***Copayment and Coinsurance*** Your Copayment and/or Coinsurance is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned a Prescription Drug Product. Special Programs: We may have certain programs in which you may receive a reduced or increased Copayment and/or Coinsurance based on your actions such as adherence/compliance to medication regimens. You may access information on these programs through the Internet at www.myuhc.com or by calling *Customer Care* at the telephone number on your ID card. NOTE: The tier status of a Prescription Drug Product can change periodically, based on the Prescription Drug List (PDL) Management Committee's periodic tiering decisions. These changes will occur no more often than annually and only on the Policy anniversary date. When that occurs, you may pay more or less for a Prescription Drug Product, depending on its tier assignment. Please access www.myuhc.com through the Internet or call *Customer Care* at the telephone number on your ID card for the most up-	For Prescription Drug Products at a retail Network Pharmacy, you are responsible for paying the lower of: • The applicable Copayment and/or Coinsurance or • The Network Pharmacy's Usual and Customary Charge for the Prescription Drug Product. For Prescription Drug Products from a mail order Network Pharmacy, you are responsible for paying the lower of: • The applicable Copayment and/or Coinsurance or • The Prescription Drug Cost for that Prescription Drug Product. See the Copayments and/or Coinsurance stated in the Benefit Information table for amounts.

Payment Term And Description	Amounts
to-date tier status.	

Benefit Information

Description and Supply Limits	Benefit (The Amount We Pay)
Specialty Prescription Drug Products	
The following supply limits apply: • As written by the provider, up to a consecutive 31-day supply of a Specialty Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits. When a Specialty Prescription Drug Product is packaged or designed to deliver in a manner that provides more than a consecutive 31-day supply, the Copayment and/or Coinsurance that applies will reflect the number of days dispensed. Supply limits apply to Specialty Prescription Drug Products obtained at a Network Pharmacy, a non-Network Pharmacy, a mail order Network Pharmacy or a Designated Pharmacy.	Your Copayment and/or Coinsurance is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned the Specialty Prescription Drug Product. All Specialty Prescription Drug Products on the Prescription Drug List are assigned to Tier-1, Tier-2, Tier-3, or Tier-4. Please access www.myuhc.com through the Internet or call *Customer Care* at the telephone number on your ID card to determine tier status. ***Network Pharmacy*** For a Tier-1 Specialty Prescription Drug Product: 100% of the Prescription Drug Cost after you pay a Copayment of $10.00 per Prescription Order or Refill. For a Tier-2 Specialty Prescription Drug Product: 100% of the Prescription Drug Cost after you pay a Copayment of $35.00 per Prescription Order or Refill. For a Tier-3 Specialty Prescription Drug Product: 100% of the Prescription Drug Cost after you pay a Copayment of $60.00 per Prescription Order or Refill. For a Tier-4 Specialty Prescription Drug Product: 100% of the Prescription Drug Cost after you pay a Copayment of $120.00 per Prescription Order or Refill. For oral chemotherapeutic agents on any Tier, 100% of the Prescription Drug cost. ***Non-Network Pharmacy*** For a Tier-1 Specialty Prescription Drug Product: 100% of the Predominant Reimbursement Rate after you pay a Copayment of $10.00 per Prescription Order or Refill. For a Tier-2 Specialty Prescription Drug Product: 100% of the Predominant Reimbursement Rate after you pay a Copayment of $35.00 per Prescription Order or Refill. For a Tier-3 Specialty Prescription Drug Product: 100% of the Predominant Reimbursement Rate after you pay a Copayment of $60.00 per Prescription Order or Refill. For a Tier-4 Specialty Prescription Drug Product: 100% of the Predominant Reimbursement Rate after you pay a Copayment of $120.00 per Prescription Order or Refill. For oral chemotherapeutic agents on any Tier, 100% of the Predominant Reimbursement Rate.

Description and Supply Limits	Benefit (The Amount We Pay)
Prescription Drugs from a Retail Network Pharmacy	
The following supply limits apply: • As written by the provider, up to a consecutive 31-day supply of a Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits. This includes contraceptive devices and outpatient contraceptive services other than oral contraceptives, which are described directly below. • A one-cycle supply of a contraceptive. You may obtain up to three cycles at one time if you pay a Copayment and/or Coinsurance for each cycle supplied. When a Prescription Drug Product is packaged or designed to deliver in a manner that provides more than a consecutive 31-day supply, the Copayment and/or Coinsurance that applies will reflect the number of days dispensed.	Your Copayment and/or Coinsurance is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are assigned to Tier-1, Tier-2, Tier-3, or Tier-4. Please access www.myuhc.com through the Internet or call *Customer Care* at the telephone number on your ID card to determine tier status. For a Tier-1 Prescription Drug Product: 100% of the Prescription Drug Cost after you pay a Copayment of $10.00 per Prescription Order or Refill. For a Tier-2 Prescription Drug Product: 100% of the Prescription Drug Cost after you pay a Copayment of $35.00 per Prescription Order or Refill. For a Tier-3 Prescription Drug Product: 100% of the Prescription Drug Cost after you pay a Copayment of $60.00 per Prescription Order or Refill. For a Tier-4 Prescription Drug Product: 100% of the Prescription Drug Cost after you pay a Copayment of $120.00 per Prescription Order or Refill. For oral chemotherapeutic agents for any Tier, 100% of the Prescription Drug Cost.
Prescription Drugs from a Retail Non-Network Pharmacy	
The following supply limits apply: • As written by the provider, up to a consecutive 31-day supply of a Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits. This includes contraceptive devices and outpatient contraceptive services other than oral contraceptives, which are described directly below. • A one-cycle supply of a contraceptive. You may obtain up to three cycles at one time if you pay a Copayment and/or Coinsurance for each cycle	Your Copayment and/or Coinsurance is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are assigned to Tier-1, Tier-2, Tier-3, or Tier-4. Please access www.myuhc.com through the Internet or call *Customer Care* at the telephone number on your ID card to determine tier status. For a Tier-1 Prescription Drug Product: 100% of the Predominant Reimbursement Rate after you pay a Copayment of $10.00 per Prescription Order or Refill. For a Tier-2 Prescription Drug Product: 100% of the Predominant Reimbursement Rate after you pay a Copayment of $35.00 per Prescription Order or Refill. For a Tier-3 Prescription Drug Product: 100% of the Predominant Reimbursement Rate after you pay a Copayment of $60.00 per Prescription Order or Refill.

Description and Supply Limits	Benefit (The Amount We Pay)
supplied. When a Prescription Drug Product is packaged or designed to deliver in a manner that provides more than a consecutive 31-day supply, the Copayment and/or Coinsurance that applies will reflect the number of days dispensed.	For a Tier-4 Prescription Drug Product: 100% of the Predominant Reimbursement Rate after you pay a Copayment of $120.00 per Prescription Order or Refill. For oral chemotherapeutic agents on any Tier, 100% of the Predominant Reimbursement Rate.
Prescription Drug Products from a Mail Order Network Pharmacy	
The following supply limits apply: • As written by the provider, up to a consecutive 90-day supply of a Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits. These supply limits do not apply to Specialty Prescription Drug Products. Specialty Prescription Drug Products from a mail order Network Pharmacy are subject to the supply limits stated above under the heading *Specialty Prescription Drug Products.* To maximize your Benefit, ask your Physician to write your Prescription Order or Refill for a 90-day supply, with refills when appropriate. You will be charged a mail order Copayment and/or Coinsurance for any Prescription Orders or Refills sent to the mail order pharmacy regardless of the number-of-days' supply written on the Prescription Order or Refill. Be sure your Physician writes your Prescription Order or Refill for a 90-day supply, not a 30-day supply with three refills.	Your Copayment and/or Coinsurance is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are assigned to Tier-1, Tier-2, Tier-3, or Tier-4. Please access www.myuhc.com through the Internet or call *Customer Care* at the telephone number on your ID card to determine tier status. For up to a 90-day supply, we pay: For a Tier-1 Prescription Drug Product: 100% of the Prescription Drug Cost after you pay a Copayment of $25.00 per Prescription Order or Refill. For a Tier-2 Prescription Drug Product: 100% of the Prescription Drug Cost after you pay a Copayment of $87.50 per Prescription Order or Refill. For a Tier-3 Prescription Drug Product: 100% of the Prescription Drug Cost after you pay a Copayment of $150.00 per Prescription Order or Refill. For a Tier-4 Prescription Drug Product: 100% of the Prescription Drug Cost after you pay a Copayment of $300.00 per Prescription Order or Refill. For oral chemotherapeutic agents on any Tier, 100% of the Prescription Drug Cost.

Outpatient Prescription Drug Rider

UnitedHealthcare Insurance Company

This Rider to the Policy is issued to the Enrolling Group and provides Benefits for Prescription Drug Products.

Because this Rider is part of a legal document, we want to give you information about the document that will help you understand it. Certain capitalized words have special meanings. We have defined these words in the *Certificate of Coverage (Certificate)* in *Section 9: Defined Terms* and in this Rider in *Section 3: Defined Terms*.

When we use the words "we," "us," and "our" in this document, we are referring to UnitedHealthcare Insurance Company. When we use the words "you" and "your" we are referring to people who are Covered Persons, as the term is defined in the *Certificate* in *Section 9: Defined Terms*.

NOTE: The Coordination of Benefits provision in the *Certificate* in *Section 7: Coordination of Benefits* applies to Prescription Drug Products covered through this Rider. Benefits for Prescription Drug Products will be coordinated with those of any other health plan in the same manner as Benefits for Covered Health Services described in the *Certificate*.

UNITEDHEALTHCARE INSURANCE COMPANY

Jeffrey Alter, President

Introduction

Coverage Policies and Guidelines

Our Prescription Drug List (PDL) Management Committee is authorized to make tier placement changes on our behalf. The PDL Management Committee makes the final classification of an FDA-approved Prescription Drug Product to a certain tier by considering a number of factors including, but not limited to, clinical and economic factors. Clinical factors may include, but are not limited to, evaluations of the place in therapy, relative safety or relative efficacy of the Prescription Drug Product, as well as whether certain supply limits or prior authorization requirements should apply. Economic factors may include, but are not limited to, the Prescription Drug Product's acquisition cost including, but not limited to, available rebates and assessments on the cost effectiveness of the Prescription Drug Product.

Some Prescription Drug Products are more cost effective for specific indications as compared to others; therefore, a Prescription Drug Product may be listed on multiple tiers according to the indication for which the Prescription Drug Product was prescribed.

We may periodically change the placement of a Prescription Drug Product among the tiers or remove Prescription Drug Products from our Prescription Drug List. These changes will occur no more often than annually and only on the Policy anniversary date.

When considering a Prescription Drug Product for tier placement, the PDL Management Committee reviews clinical and economic factors regarding Covered Persons as a general population. Whether a particular Prescription Drug Product is appropriate for an individual Covered Person is a determination that is made by the Covered Person and the prescribing Physician.

NOTE: The tier status of a Prescription Drug Product may change periodically based on the process described above. As a result of such changes, you may be required to pay more or less for that Prescription Drug Product. Please access www.myuhc.com through the Internet or call *Customer Care* at the telephone number on your ID card for the most up-to-date tier status.

Prescription Drug List

If we make an Adverse Determination regarding Benefits for a Prescription Drug Product because it is not included either on Tier 1 or Tier 2 of our Prescription Drug List (sometimes called a drug formulary), you have the right to request a review by an Independent Review Organization (IRO). See *Section 6: Questions, Complaints and Appeals* of your *Certificate* for a description of the Adverse Determination appeal process.

Identification Card (ID Card) - Network Pharmacy

You must either show your ID card at the time you obtain your Prescription Drug Product at a Network Pharmacy or you must provide the Network Pharmacy with identifying information that can be verified by us during regular business hours.

If you don't show your ID card or provide verifiable information at a Network Pharmacy, you will be required to pay the Usual and Customary Charge for the Prescription Drug Product at the pharmacy.

You may seek reimbursement from us as described in the *Certificate* in *Section 5: How to File a Claim*. When you submit a claim on this basis, you may pay more because you failed to verify your eligibility when the Prescription Drug Product was dispensed. The amount you are reimbursed will be based on the Prescription Drug Cost, less the required Copayment and/or Coinsurance, and any deductible that applies.

Submit your claim to the Pharmacy Benefit Manager claims address noted on your ID card.

Designated Pharmacies

If you require certain Prescription Drug Products, including, but not limited to, Specialty Prescription Drug Products, we may direct you to a Designated Pharmacy with whom we have an arrangement to provide those Prescription Drug Products.

If you are directed to a Designated Pharmacy and you choose not to obtain your Prescription Drug Product from a Designated Pharmacy, you will be subject to the non-Network Benefit for that Prescription Drug Product.

Limitation on Selection of Pharmacies

If we determine that you may be using Prescription Drug Products in a harmful or abusive manner, or with harmful frequency, your selection of pharmacies may be limited. If this happens, we may require you to select a single pharmacy that will provide and coordinate all future pharmacy services. Benefits will be paid only if you use the designated single pharmacy. If you don't make a selection within 31 days of the date we notify you, we will select a single pharmacy for you.

Special Programs

We may have certain programs in which you may receive an enhanced or reduced Benefit based on your actions such as adherence/compliance to medication regimens. You may access information on these programs through the Internet at www.myuhc.com or by calling *Customer Care* at the telephone number on your ID card.

Outpatient Prescription Drug Rider Table of Contents

Section 1: Benefits for Prescription Drug Products

Benefits are available for Prescription Drug Products at either a Network Pharmacy or a non-Network Pharmacy and are subject to Copayments and/or Coinsurance or other payments that vary depending on which of the tiers of the Prescription Drug List the Prescription Drug Product is listed. Refer to the *Outpatient Prescription Drug Schedule of Benefits* for applicable Copayments and/or Coinsurance requirements.

Benefits for Prescription Drug Products are available when the Prescription Drug Product meets the definition of a Covered Health Service or is prescribed to prevent conception.

Specialty Prescription Drug Products

Benefits are provided for Specialty Prescription Drug Products.

If you require Specialty Prescription Drug Products, we may direct you to a Designated Pharmacy with whom we have an arrangement to provide those Specialty Prescription Drug Products.

If you are directed to a Designated Pharmacy and you choose not to obtain your Specialty Prescription Drug Product from a Designated Pharmacy, you will be subject to the non-Network Benefit for that Specialty Prescription Drug Product.

Please see *Section 3: Defined Terms* for a full description of Specialty Prescription Drug Product and Designated Pharmacy.

Refer to the *Outpatient Prescription Drug Schedule of Benefits* for details on Specialty Prescription Drug Product supply limits.

Prescription Drugs from a Retail Network Pharmacy

Benefits are provided for Prescription Drug Products dispensed by a retail Network Pharmacy.

Refer to the *Outpatient Prescription Drug Schedule of Benefits* for details on retail Network Pharmacy supply limits.

Prescription Drugs from a Retail Non-Network Pharmacy

Benefits are provided for Prescription Drug Products dispensed by a retail non-Network Pharmacy.

If the Prescription Drug Product is dispensed by a retail non-Network Pharmacy, you must pay for the Prescription Drug Product at the time it is dispensed and then file a claim for reimbursement with us, as described in *Section 5* of your *Certificate*. We will not reimburse you for the difference between the Predominant Reimbursement Rate and the non-Network Pharmacy's Usual and Customary Charge for that Prescription Drug Product. We will not reimburse you for any non-covered drug product.

In most cases, you will pay more if you obtain Prescription Drug Products from a non-Network Pharmacy.

Refer to the *Outpatient Prescription Drug Schedule of Benefits* for details on retail non-Network Pharmacy supply limits.

Prescription Drug Products from a Mail Order Network Pharmacy

Benefits are provided for certain Prescription Drug Products dispensed by a mail order Network Pharmacy.

Refer to the *Outpatient Prescription Drug Schedule of Benefits* for details on mail order Network Pharmacy supply limits.

Please access www.myuhc.com through the Internet or call *Customer Care* at the telephone number on your ID card to determine if Benefits are provided for your Prescription Drug Product and for information on how to obtain your Prescription Drug Product through a mail order Network Pharmacy.

Section 2: Exclusions

Exclusions from coverage listed in the *Certificate* apply also to this Rider, except that any preexisting condition exclusion in the *Certificate* is not applicable to this Rider. In addition, the exclusions listed below apply.

1. Coverage for Prescription Drug Products for the amount dispensed (days' supply or quantity limit) which exceeds the supply limit.
2. Prescription Drug Products dispensed outside the United States, except as required for Emergency treatment.
3. Drugs which are prescribed, dispensed or intended for use during an Inpatient Stay.
4. Experimental or Investigational or Unproven Services and medications; medications used for experimental indications and/or dosage regimens determined by us to be experimental, investigational or unproven. This exclusion will not apply to drugs prescribed to treat a chronic, disabling, or life-threatening illness if the drug is both of the following:
    - Has been approved by the U.S. Food and Drug Administration (FDA) for at least one indication.
    - Is recognized for treatment of the indication for which the drug is prescribed in either of the following:
        - A prescription drug reference compendium approved by the *Commissioner of the Texas Department of Insurance*.
        - Substantially accepted peer-reviewed medical literature.
5. Prescription Drug Products furnished by the local, state or federal government. Any Prescription Drug Product to the extent payment or benefits are provided or available from the local, state or federal government (for example, Medicare) whether or not payment or benefits are received, except as otherwise provided by law.
6. Prescription Drug Products for any condition, Injury, Sickness or mental illness arising out of, or in the course of, employment for which benefits are available under any workers' compensation law or other similar laws, whether or not a claim for such benefits is made or payment or benefits are received.
7. Any product dispensed for the purpose of appetite suppression or weight loss.
8. A Pharmaceutical Product for which Benefits are provided in your *Certificate*. This exclusion does not apply to Depo Provera and other injectable drugs used for contraception.
9. Durable Medical Equipment. Prescribed and non-prescribed outpatient supplies, other than the diabetic supplies and inhaler spacers specifically stated as covered.
10. General vitamins, except the following which require a Prescription Order or Refill: prenatal vitamins, vitamins with fluoride, and single entity vitamins.
11. Unit dose packaging of Prescription Drug Products.
12. Medications used for cosmetic purposes.
13. Prescription Drug Products, including New Prescription Drug Products or new dosage forms, that we determine do not meet the definition of a Covered Health Service.
14. Prescription Drug Products as a replacement for a previously dispensed Prescription Drug Product that was lost, stolen, broken or destroyed.

15. Prescription Drug Products when prescribed to treat infertility.

16. Prescription Drug Products for smoking cessation.

17. Compounded drugs that do not contain at least one ingredient that has been approved by the *U.S. Food and Drug Administration (FDA)* and requires a Prescription Order or Refill. Compounded drugs that are available as a similar commercially available Prescription Drug Product. (Compounded drugs that contain at least one ingredient that requires a Prescription Order or Refill are assigned to Tier-4.)

18. Drugs available over-the-counter that do not require a Prescription Order or Refill by federal or state law before being dispensed, unless we have designated the over-the-counter medication as eligible for coverage as if it were a Prescription Drug Product and it is obtained with a Prescription Order or Refill from a Physician. Prescription Drug Products that are available in over-the-counter form or comprised of components that are available in over-the-counter form or equivalent. Certain Prescription Drug Products that we have determined are Therapeutically Equivalent to an over-the-counter drug. Such determinations may be made up to six times during a calendar year, and we may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision. This exclusion does not apply to over-the-counter items for which Benefits are provided as described in the *Certificate* under *Diabetes Services* in *Section 1: Covered Health Services*.

19. New Prescription Drug Products and/or new dosage forms until the date they are assigned to a tier by our PDL Management Committee.

20. Growth hormone for children with familial short stature (short stature based upon heredity and not caused by a diagnosed medical condition).

21. Any product for which the primary use is a source of nutrition, nutritional supplements, or dietary management of disease, even when used for the treatment of Sickness or Injury. This exclusion does not apply to:

    - Nutritional supplements for the treatment of Autism Spectrum Disorders, as described in *Section 1: Covered Health Services* of the *Certificate*, which meet the definition of a Covered Health Service.
    - Amino acid-based elemental formulas as described under *Amino Acid-Based Elemental Formulas* in *Section 1: Covered Health Services* of the *Certificate*.
    - Formulas for phenylketonuria (PKU) or other heritable diseases.

22. A Prescription Drug Product that contains (an) active ingredient(s) available in and Therapeutically Equivalent to another covered Prescription Drug Product. Such determinations may be made up to six times during a calendar year, and we may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.

23. A Prescription Drug Product that contains (an) active ingredient(s) which is (are) a modified version of and Therapeutically Equivalent to another covered Prescription Drug Product. Such determinations may be made up to six times during a calendar year, and we may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.

Section 3: Defined Terms

Brand-name - a Prescription Drug Product: (1) which is manufactured and marketed under a trademark or name by a specific drug manufacturer; or (2) that we identify as a Brand-name product, based on available data resources including, but not limited to, First DataBank, that classify drugs as either brand or generic based on a number of factors. You should know that all products identified as a "brand name" by the manufacturer, pharmacy, or your Physician may not be classified as Brand-name by us.

Chemically Equivalent - when Prescription Drug Products contain the same active ingredient.

Designated Pharmacy - a pharmacy that has entered into an agreement with us or with an organization contracting on our behalf, to provide specific Prescription Drug Products, including, but not limited to, Specialty Prescription Drug Products. The fact that a pharmacy is a Network Pharmacy does not mean that it is a Designated Pharmacy.

Generic - a Prescription Drug Product: (1) that is Chemically Equivalent to a Brand-name drug; or (2) that we identify as a Generic product based on available data resources including, but not limited to, First DataBank, that classify drugs as either brand or generic based on a number of factors. You should know that all products identified as a "generic" by the manufacturer, pharmacy or your Physician may not be classified as a Generic by us.

Network Pharmacy - a pharmacy that has:

- Entered into an agreement with us or an organization contracting on our behalf to provide Prescription Drug Products to Covered Persons.
- Agreed to accept specified reimbursement rates for dispensing Prescription Drug Products.
- Been designated by us as a Network Pharmacy.

New Prescription Drug Product - a Prescription Drug Product or new dosage form of a previously approved Prescription Drug Product, for the period of time starting on the date the Prescription Drug Product or new dosage form is approved by the *U.S. Food and Drug Administration (FDA)* and ending on the earlier of the following dates:

- The date it is assigned to a tier by our PDL Management Committee.
- December 31st of the following calendar year.

Predominant Reimbursement Rate - the amount we will pay to reimburse you for a Prescription Drug Product that is dispensed at a non-Network Pharmacy. The Predominant Reimbursement Rate for a particular Prescription Drug Product dispensed at a non-Network Pharmacy includes a dispensing fee and any applicable sales tax. We calculate the Predominant Reimbursement Rate using our Prescription Drug Cost that applies for that particular Prescription Drug Product at most Network Pharmacies.

Prescription Drug Cost - the rate we have agreed to pay our Network Pharmacies, including a dispensing fee and any applicable sales tax, for a Prescription Drug Product dispensed at a Network Pharmacy.

Prescription Drug List - a list that categorizes into tiers medications, products or devices that have been approved by the *U.S. Food and Drug Administration (FDA)*. This list is subject to our periodic review and modification. These changes will occur no more often than annually and only on the Policy anniversary date. You may determine to which tier a particular Prescription Drug Product has been assigned through the Internet at www.myuhc.com or by calling *Customer Care* at the telephone number on your ID card.

Prescription Drug List (PDL) Management Committee - the committee that we designate for, among other responsibilities, classifying Prescription Drug Products into specific tiers.

Prescription Drug Product - a medication, product or device that has been approved by the *U.S. Food and Drug Administration (FDA)* and that can, under federal or state law, be dispensed only pursuant to a Prescription Order or Refill. A Prescription Drug Product includes a medication that, due to its characteristics, is appropriate for self-administration or administration by a non-skilled caregiver. For the purpose of Benefits under the Policy, this definition includes:

- Inhalers (with spacers).
- Insulin.
- The diabetic supplies listed below:
  - Standard insulin syringes with needles.
  - Blood-testing strips - glucose.
  - Urine-testing strips - glucose.
  - Ketone-testing strips and tablets.
  - Lancets and lancet devices.
  - Glucose monitors.
  - Prescription and non-prescription oral agents for controlling blood sugar levels.
  - Other diabetic supplies and services as described in *Section 1: Covered Health Services* of your *Certificate*.
- Nutritional supplements for the treatment of Autism Spectrum Disorders, as described in *Section 1: Covered Health Services* of your *Certificate*, which meet the definition of a Covered Health Service.
- Amino acid-based elemental formulas as described under *Amino Acid-Based Elemental Formulas* in *Section 1: Covered Health Services* of your *Certificate*.
- Formulas necessary for the treatment of phenylketonuria (PKU) or other heritable diseases.

Prescription Order or Refill - the directive to dispense a Prescription Drug Product issued by a duly licensed health care provider whose scope of practice permits issuing such a directive.

Specialty Prescription Drug Product - Prescription Drug Products that are generally high cost, self-administered biotechnology drugs used to treat patients with certain illnesses. You may access a complete list of Specialty Prescription Drug Products through the Internet at www.myuhc.com or by calling *Customer Care* at the telephone number on your ID card.

Therapeutically Equivalent - when Prescription Drug Products can be expected to produce essentially the same therapeutic outcome and toxicity.

Usual and Customary Charge - the usual fee that a pharmacy charges individuals for a Prescription Drug Product without reference to reimbursement to the pharmacy by third parties. The Usual and Customary Charge includes a dispensing fee and any applicable sales tax.

Important Notices under the Patient Protection and Affordable Care Act (PPACA)

IMPORTANT NOTICE: If you have a dependent child whose coverage ended or who was denied coverage (or was not eligible for coverage) because dependent coverage of children was not available up to age 26, you may have the right to enroll that dependent under a special dependent child enrollment period. This right applies as of the first day of the first plan year beginning on or after September 23, 2010 and your employer (or enrolling group) must provide you with at least a 30 day enrollment period. If you are adding a dependent child during this special enrollment period and have a choice of coverage options under the plan, you will be allowed to change options. This child special open enrollment may coincide with your annual open enrollment, if you have one. Please contact your employer or group plan administrator for more information.

IMPORTANT NOTICE: If coverage or benefits for you or a dependent ended due to reaching a lifetime limit, be advised that a lifetime limit on the dollar value of benefits no longer applies. If you are covered under the plan, you are once again eligible for benefits. Additionally, if you are not enrolled in the plan, but are still eligible for coverage, then you will have a 30 day opportunity to request enrollment. This 30 day enrollment opportunity will begin no later than the first day of the first plan year beginning on or after September 23, 2010. This 30 day enrollment period may coincide with your annual open enrollment, if you have one. Please contact your employer or group health plan administrator for more information.

Changes in Federal Law that Impact Benefits

There are changes in Federal law which may impact coverage and Benefits stated in the *Certificate of Coverage (Certificate)* and *Schedule of Benefits*. A summary of those changes and the dates the changes are effective appear below.

Patient Protection and Affordable Care Act (PPACA)

Effective for policies that are new or renewing on or after September 23, 2010, the requirements listed below apply.

- Lifetime limits on the dollar amount of essential benefits available to you under the terms of your plan are no longer permitted. Essential benefits include the following:

  Ambulatory patient services; emergency services, hospitalization; maternity and newborn care, mental health and substance use disorder services (including behavioral health treatment); prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

- On or before the first day of the first plan year beginning on or after September 23, 2010, the enrolling group will provide a 30 day enrollment period for those individuals who are still eligible under the plan's eligibility terms but whose coverage ended by reason of reaching a lifetime limit on the dollar value of all benefits.

- Essential benefits for plan years beginning prior to January 1, 2014 can only be subject to restricted annual limits. Restricted annual limits for each person covered under the plan may be no less than the following:

  - For plan or policy years beginning on or after September 23, 2010 but before September 23, 2011, $750,000.

  - For plan or policy years beginning on or after September 23, 2011 but before September 23, 2012, $1,250,000.

  - For plan or policy years beginning on or after September 23, 2012 but before January 1, 2014, $2,000,000.

- Any pre-existing condition exclusions (including denial of benefits or coverage) will not apply to covered persons under the age of 19.

- Coverage for enrolled dependent children is no longer conditioned upon full-time student status or other dependency requirements and will remain in place until the child's 26th birthday. If you have a grandfathered plan, the enrolling group is not required to extend coverage to age 26 if the child is eligible to enroll in an eligible employer-sponsored health plan (as defined by law). Under the *PPACA* a plan generally is "grandfathered" if it was in effect on March 23, 2010 and there are no substantial changes in the benefit design as described in the *Interim Final Rule on Grandfathered Health Plans*.

  On or before the first day of the first plan year beginning on or after September 23, 2010, the enrolling group will provide a 30 day dependent child special open enrollment period for dependent children who are not currently enrolled under the policy and who have not yet reached age 26. During this dependent child special open enrollment period, subscribers who are adding a dependent child and who have a choice of coverage options will be allowed to change options.

- If your plan includes coverage for enrolled dependent children beyond the age of 26, which is conditioned upon full-time student status, the following applies:

Coverage for enrolled dependent children who are required to maintain full-time student status in order to continue eligibility under the policy is subject to the statute known as *Michelle's Law*. This law amends *ERISA*, the *Public Health Service Act*, and the *Internal Revenue Code* and requires group health plans, which provide coverage for dependent children who are post-secondary school students, to continue such coverage if the student loses the required student status because he or she must take a medically necessary leave of absence from studies due to a serious illness or Injury.

- If you do not have a grandfathered plan, in-network benefits for preventive care services described below will be paid at 100%, and not subject to any deductible, coinsurance or copayment. If you have pharmacy benefit coverage, your plan may also be required to cover preventive care medications that are obtained at a network pharmacy at 100%, and not subject to any deductible, coinsurance or copayment, as required by applicable law under any of the following:
  - Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the *United States Preventive Services Task Force*.
  - Immunizations that have in effect a recommendation from the *Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention*.
  - With respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the *Health Resources and Services Administration*.
  - With respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the *Health Resources and Services Administration*.
- Retroactive rescission of coverage under the policy is permitted, with 30 days advance written notice, only in the following two circumstances:
  - The individual performs an act, practice or omission that constitutes fraud.
  - The individual makes an intentional misrepresentation of a material fact.
- Other changes provided for under the *PPACA* do not impact your plan because your plan already contains these benefits. These include:
  - Direct access to OB/GYN care without a referral or authorization requirement.
  - The ability to designate a pediatrician as a primary care physician (PCP) if your plan requires a PCP designation.
  - Prior authorization is not required before you receive services in the emergency department of a hospital.

    If you seek emergency care from out-of-network providers in the emergency department of a hospital your cost sharing obligations (copayments/coinsurance) will be the same as would be applied to care received from in-network providers.

Some Important Information about Appeal and External Review Rights under PPACA

If you are enrolled in a non-grandfathered plan with an effective date or plan year anniversary on or after September 23, 2010, the *Patient Protection and Affordable Care Act of 2010 (PPACA)*, as amended, sets forth new and additional internal appeal and external review rights beyond those that some plans may have previously offered. Also, certain grandfathered plans are complying with the additional internal appeal and external review rights provisions on a voluntary basis. Please refer to your benefit plan documents, including amendments and notices, or speak with your employer or UnitedHealthcare for

more information on the appeal rights available to you. (Also, please refer to the *Claims and Appeal Notice* section of this document.)

What if I receive a denial, and need help understanding it? Please call UnitedHealthcare at the number listed on the back of your health plan ID card.

What if I don't agree with the denial? You have a right to appeal any decision to not pay for an item or service.

How do I file an appeal? The initial denial letter or *Explanation of Benefits* that you receive from UnitedHealthcare will give you the information and the timeframe to file an appeal.

What if my situation is urgent? If your situation is urgent, your review will be conducted as quickly as possible. If you believe your situation is urgent, you may request an expedited review, and, if applicable, file an external review at the same time. For help call UnitedHealthcare at the number listed on the back of your health plan ID card.

Generally, an urgent situation is when your health may be in serious jeopardy. Or when, in the opinion of your doctor, you may be experiencing severe pain that cannot be adequately controlled while you wait for a decision on your appeal.

Who may file an appeal? Any member or someone that member names to act as an authorized representative may file an appeal. For help call UnitedHealthcare at the number listed on the back of your health plan ID card.

Can I provide additional information about my claim? Yes, you may give us additional information supporting your claim. Send the information to the address provided in the initial denial letter or *Explanation of Benefits*.

Can I request copies of information relating to my claim? Yes. There is no cost to you for these copies. Send your request to the address provided in the initial denial letter or *Explanation of Benefits*.

What happens if I don't agree with the outcome of my appeal? If you appeal, we will review our decision. We will also send you our written decision within the time allowed. If you do not agree with the decision, you may be able to request an external review of your claim by an independent third party. They will review the denial and issue a final decision.

If I need additional help, what should I do? For questions on your appeal rights, you may call UnitedHealthcare at the number listed on the back of your health plan ID card. You may also contact the support groups listed below.

Are verbal translation services available to me during an appeal? Yes. Contact UnitedHealthcare at the number listed on the back of your health plan ID card. Ask for verbal translation services for your questions.

Is there other help available to me? For questions about appeal rights, an unfavorable benefit decision, or for help, you may also contact the *Employee Benefits Security Administration* at 1-866-444-EBSA (3272). Your state consumer assistance program may also be able to help you.

For information on appeals and other *PPACA* regulations, visit www.healthcare.gov.

Mental Health/Substance Use Disorder Parity

Effective for Policies that are new or renewing on or after July 1, 2010, Benefits are subject to final regulations supporting the *Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA)*. Benefits for mental health conditions and substance use disorder conditions that are Covered Health Services under the Policy must be treated in the same manner and provided at the same level as Covered Health Services for the treatment of other Sickness or Injury. Benefits for Mental Health Services and Substance

Use Disorder Services are not subject to any annual maximum benefit limit (including any day, visit or dollar limit).

MHPAEA requires that the financial requirements for coinsurance and copayments for mental health and substance use disorder conditions must be no more restrictive than those coinsurance and copayment requirements for substantially all medical/surgical benefits. *MHPAEA* requires specific testing to be applied to classifications of benefits to determine the impact of these financial requirements on mental health and substance use disorder benefits. Based upon the results of that testing, it is possible that coinsurance or copayments that apply to mental health conditions and substance use disorder conditions in your benefit plan may be reduced.

Women's Health and Cancer Rights Act of 1998

As required by the *Women's Health and Cancer Rights Act of 1998*, Benefits under the Policy are provided for mastectomy, including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymphedema).

If you are receiving Benefits in connection with a mastectomy, Benefits are also provided for the following Covered Health Services, as you determine appropriate with your attending Physician:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and treatment of physical complications of the mastectomy, including lymphedema.

The amount you must pay for such Covered Health Services (including Copayments, Coinsurance and any Annual Deductible) are the same as are required for any other Covered Health Service. Limitations on Benefits are the same as for any other Covered Health Service.

Statement of Rights under the Newborns' and Mothers' Health Protection Act

Under Federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not restrict Benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider (e.g. your Physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under Federal law, plans and issuers may not set the level of Benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under Federal law, require that a Physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of- pocket costs, you may be required to obtain precertification. For information on precertification, contact your issuer.

Claims and Appeal Notice

This Notice is provided to you in order to describe our responsibilities under Federal law for making benefit determinations and your right to appeal adverse benefit determinations. To the extent that state law provides you with more generous timelines or opportunities for appeal, those rights also apply to you. Please refer to your benefit documents for information about your rights under state law.

Benefit Determinations

Post-service Claims

Post-service claims are those claims that are filed for payment of Benefits after medical care has been received. If your post-service claim is denied, you will receive a written notice from us within 30 days of receipt of the claim, as long as all needed information was provided with the claim. We will notify you within this 30 day period if additional information is needed to process the claim, and may request a one time extension not longer than 15 days and pend your claim until all information is received.

Once notified of the extension, you then have 45 days to provide this information. If all of the needed information is received within the 45-day time frame, and the claim is denied, we will notify you of the denial within 15 days after the information is received. If you don't provide the needed information within the 45-day period, your claim will be denied.

A denial notice will explain the reason for denial, refer to the part of the plan on which the denial is based, and provide the claim appeal procedures.

If you have prescription drug Benefits and are asked to pay the full cost of a prescription when you fill it at a retail or mail-order pharmacy, and if you believe that it should have been paid under the Policy, you may submit a claim for reimbursement in accordance with the applicable claim filing procedures. If you pay a Copayment and believe that the amount of the Copayment was incorrect, you also may submit a claim for reimbursement in accordance with the applicable claim filing procedures. When you have filed a claim, your claim will be treated under the same procedures for post-service group health plan claims as described in this section.

Pre-service Requests for Benefits

Pre-service requests for Benefits are those requests that require notification or approval prior to receiving medical care. If you have a pre-service request for Benefits, and it was submitted properly with all needed information, you will receive written notice of the decision from us within 15 days of receipt of the request. If you filed a pre-service request for Benefits improperly, we will notify you of the improper filing and how to correct it within five days after the pre-service request for Benefits was received. If additional information is needed to process the pre-service request, we will notify you of the information needed within 15 days after it was received, and may request a one time extension not longer than 15 days and pend your request until all information is received. Once notified of the extension you then have 45 days to provide this information. If all of the needed information is received within the 45-day time frame, we will notify you of the determination within 15 days after the information is received. If you don't provide the needed information within the 45-day period, your request for Benefits will be denied. A denial notice will explain the reason for denial, refer to the part of the plan on which the denial is based, and provide the appeal procedures.

If you have prescription drug Benefits and a retail or mail order pharmacy fails to fill a prescription that you have presented, you may file a pre-service health request for Benefits in accordance with the applicable claim filing procedure. When you have filed a request for Benefits, your request will be treated under the same procedures for pre-service group health plan requests for Benefits as described in this section.

Urgent Requests for Benefits that Require Immediate Attention

Urgent requests for Benefits are those that require notification or a benefit determination prior to receiving medical care, where a delay in treatment could seriously jeopardize your life or health, or the ability to regain maximum function or, in the opinion of a Physician with knowledge of your medical condition, could cause severe pain. In these situations, you will receive notice of the benefit determination in writing or electronically within 72 hours after we receive all necessary information, taking into account the seriousness of your condition.

If you filed an urgent request for Benefits improperly, we will notify you of the improper filing and how to correct it within 24 hours after the urgent request was received. If additional information is needed to process the request, we will notify you of the information needed within 24 hours after the request was received. You then have 48 hours to provide the requested information.

You will be notified of a benefit determination no later than 48 hours after:

- Our receipt of the requested information; or
- The end of the 48-hour period within which you were to provide the additional information, if the information is not received within that time.

A denial notice will explain the reason for denial, refer to the part of the plan on which the denial is based, and provide the claim appeal procedures.

Concurrent Care Claims

If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and your request to extend the treatment is an urgent request for Benefits as defined above, your request will be decided within 24 hours, provided your request is made at least 24 hours prior to the end of the approved treatment. We will make a determination on your request for the extended treatment within 24 hours from receipt of your request.

If your request for extended treatment is not made at least 24 hours prior to the end of the approved treatment, the request will be treated as an urgent request for Benefits and decided according to the timeframes described above. If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and you request to extend treatment in a non-urgent circumstance, your request will be considered a new request and decided according to post-service or pre-service timeframes, whichever applies.

Questions or Concerns about Benefit Determinations

If you have a question or concern about a benefit determination, you may informally contact our *Customer Care* department before requesting a formal appeal. If the *Customer Care* representative cannot resolve the issue to your satisfaction over the phone, you may submit your question in writing. However, if you are not satisfied with a benefit determination as described above, you may appeal it as described below, without first informally contacting a *Customer Care* representative. If you first informally contact our *Customer Care* department and later wish to request a formal appeal in writing, you should again contact *Customer Care* and request an appeal. If you request a formal appeal, a *Customer Care* representative will provide you with the appropriate address.

If you are appealing an urgent claim denial, please refer to *Urgent Appeals that Require Immediate Action* below and contact our *Customer Care* department immediately.

How to Appeal a Claim Decision

If you disagree with a pre-service request for Benefits determination or post-service claim determination or a rescission of coverage determination after following the above steps, you can contact us in writing to formally request an appeal.

Your request should include:

- The patient's name and the identification number from the ID card.
- The date(s) of medical service(s).
- The provider's name.
- The reason you believe the claim should be paid.
- Any documentation or other written information to support your request for claim payment.

Your first appeal request must be submitted to us within 180 days after you receive the claim denial.

Appeal Process

A qualified individual who was not involved in the decision being appealed will be appointed to decide the appeal. If your appeal is related to clinical matters, the review will be done in consultation with a health care professional with appropriate expertise in the field, who was not involved in the prior determination. We may consult with, or seek the participation of, medical experts as part of the appeal resolution process. You consent to this referral and the sharing of pertinent medical claim information. Upon request and free of charge, you have the right to reasonable access to and copies of all documents, records, and other information relevant to your claim for Benefits. In addition, if any new or additional evidence is relied upon or generated by us during the determination of the appeal, we will provide it to you free of charge and sufficiently in advance of the due date of the response to the adverse benefit determination.

Appeals Determinations

Pre-service Requests for Benefits and Post-service Claim Appeals

You will be provided written or electronic notification of the decision on your appeal as follows:

- For appeals of pre-service requests for Benefits as identified above, the first level appeal will be conducted and you will be notified of the decision within 15 days from receipt of a request for appeal of a denied request for Benefits. The second level appeal will be conducted and you will be notified of the decision within 15 days from receipt of a request for review of the first level appeal decision.
- For appeals of post-service claims as identified above, the first level appeal will be conducted and you will be notified of the decision within 30 days from receipt of a request for appeal of a denied claim. The second level appeal will be conducted and you will be notified of the decision within 30 days from receipt of a request for review of the first level appeal decision.

For procedures associated with urgent requests for Benefits, see *Urgent Appeals that Require Immediate Action* below.

If you are not satisfied with the first level appeal decision, you have the right to request a second level appeal. Your second level appeal request must be submitted to us within 60 days from receipt of the first level appeal decision.

Please note that our decision is based only on whether or not Benefits are available under the Policy for the proposed treatment or procedure. We don't determine whether the pending health service is necessary or appropriate. That decision is between you and your Physician.

Urgent Appeals that Require Immediate Action

Your appeal may require immediate action if a delay in treatment could significantly increase the risk to your health, or the ability to regain maximum function, or cause severe pain. In these urgent situations:

- The appeal does not need to be submitted in writing. You or your Physician should call us as soon as possible.
- We will provide you with a written or electronic determination within 72 hours following receipt of your request for review of the determination, taking into account the seriousness of your condition.

Health Plan Notices of Privacy Practices

Medical Information Privacy Notice

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

We* are required by law to protect the privacy of your health information. We are also required to send you this notice, which explains how we may use information about you and when we can give out or "disclose" that information to others. You also have rights regarding your health information that are described in this notice. We are required by law to abide by the terms of this notice.

The terms "information" or "health information" in this notice include any information we maintain that reasonably can be used to identify you and that relates to your physical or mental health condition, the provision of health care to you, or the payment for such health care.

We have the right to change our privacy practices and the terms of this notice. If we make a material change to our privacy practices, we will provide to you a revised notice by direct mail or electronically as permitted by applicable law. In all cases, we will post the revised notice on our website www.myuhc.com. We reserve the right to make any revised or changed notice effective for information we already have and for information that we receive in the future.

**For purposes of this Notice of Privacy Practices, "we" or "us" refers to the following health plans that are affiliated with UnitedHealth Group:*

ACN Group of California, Inc.; All Savers Insurance Company; All Savers Life Insurance Company of California; American Medical Security Life Insurance Company; AmeriChoice of Connecticut, Inc.; AmeriChoice of Georgia, Inc.; AmeriChoice of New Jersey, Inc.; Arizona Physicians IPA, Inc.; Citrus Health Care, Inc.; Dental Benefit Providers of California, Inc.; Dental Benefit Providers of Illinois, Inc.; Evercare of Arizona, Inc.; Evercare of New Mexico, Inc.; Evercare of Texas, LLC; Golden Rule Insurance Company; Health Plan of Nevada, Inc.; MAMSI Life and Health Insurance Company; MD-Individual Practice Association, Inc.; Midwest Security Life Insurance Company; National Pacific Dental, Inc.; Neighborhood Health Partnership, Inc.; Nevada Pacific Dental; Optimum Choice, Inc.; Oxford Health Insurance, Inc.; Oxford Health Plans (CT), Inc.; Oxford Health Plans (NJ), Inc.; Oxford Health Plans (NY), Inc.; PacifiCare Life and Health Insurance Company; PacifiCare Life Assurance Company; Physicians Health Choice of Texas, LLC; Sierra Health & Life Insurance Co., Inc.; UHC of California; U.S. Behavioral Health Plan, California; Unimerica Insurance Company; Unimerica Life Insurance Company of New York; Unison Family Health Plan of Pennsylvania, Inc.; Unison Health Plan of Delaware, Inc.; Unison Health Plan of Pennsylvania, Inc.; Unison Health Plan of Tennessee, Inc.; Unison Health Plan of the Capital Area, Inc.; United Behavioral Health; UnitedHealthcare Benefits of Texas, Inc.; *UnitedHealthcare Community Plan of Ohio, Inc.*; *UnitedHealthcare Insurance Company; UnitedHealthcare Insurance Company of Illinois; UnitedHealthcare Insurance Company of New York; UnitedHealthcare Insurance Company of the River Valley; UnitedHealthcare Insurance Company of Ohio; UnitedHealthcare of Alabama, Inc.; UnitedHealthcare of Arizona, Inc.; UnitedHealthcare of Arkansas, Inc.; UnitedHealthcare of Colorado, Inc.; UnitedHealthcare of Florida, Inc.; UnitedHealthcare of Georgia, Inc.; UnitedHealthcare of Illinois, Inc.; UnitedHealthcare of Kentucky, Ltd.; UnitedHealthcare of Louisiana, Inc.; UnitedHealthcare of the Mid-Atlantic, Inc.; UnitedHealthcare of the Great Lakes Health Plan, Inc.; UnitedHealthcare of the Midlands, Inc.; UnitedHealthcare of the Midwest, Inc.; United HealthCare of Mississippi, Inc.; UnitedHealthcare of New England, Inc.; UnitedHealthcare of New York, Inc.; UnitedHealthcare of North Carolina, Inc.; UnitedHealthcare of Ohio, Inc.; UnitedHealthcare of Oklahoma, Inc.; UnitedHealthcare of Oregon, Inc.; UnitedHealthcare of Pennsylvania, Inc.; UnitedHealthcare of South Carolina, Inc.; UnitedHealthcare of Texas, Inc.; UnitedHealthcare of Utah, Inc.; UnitedHealthcare of Washington, Inc.; UnitedHealthcare of Wisconsin, Inc.; UnitedHealthcare Plan of the River Valley, Inc.*

How We Use or Disclose Information

We must use and disclose your health information to provide that information:

- To you or someone who has the legal right to act for you (your personal representative) in order to administer your rights as described in this notice; and
- To the *Secretary of the Department of Health and Human Services*, if necessary, to make sure your privacy is protected.

We have the right to use and disclose health information for your treatment, to pay for your health care and to operate our business. For example, we may use or disclose your health information:

- **For Payment** of premiums due us, to determine your coverage, and to process claims for health care services you receive, including for subrogation or coordination of other benefits you may have. For example, we may tell a doctor whether you are eligible for coverage and what percentage of the bill may be covered.
- **For Treatment.** We may use or disclose health information to aid in your treatment or the coordination of your care. For example, we may disclose information to your physicians or hospitals to help them provide medical care to you.
- **For Health Care Operations.** We may use or disclose health information as necessary to operate and manage our business activities related to providing and managing your health care coverage. For example, we might talk to your physician to suggest a disease management or wellness program that could help improve your health or we may analyze data to determine how we can improve our services.
- **To Provide You Information on Health Related Programs or Products** such as alternative medical treatments and programs or about health-related products and services, subject to limits imposed by law.
- **For Plan Sponsors.** If your coverage is through an employer sponsored group health plan, we may share summary health information and enrollment and disenrollment information with the plan sponsor. In addition, we may share other health information with the plan sponsor for plan administration if the plan sponsor agrees to special restrictions on its use and disclosure of the information in accordance with federal law.
- **For Reminders.** We may use or disclose health information to send you reminders about your benefits or care, such as appointment reminders with providers who provide medical care to you.

We may use or disclose your health information for the following purposes under limited circumstances:

- **As Required by Law.** We may disclose information when required to do so by law.
- **To Persons Involved With Your Care.** We may use or disclose your health information to a person involved in your care or who helps pay for your care, such as a family member, when you are incapacitated or in an emergency, or when you agree or fail to object when given the opportunity. If you are unavailable or unable to object, we will use our best judgment to decide if the disclosure is in your best interests.
- **For Public Health Activities** such as reporting or preventing disease outbreaks.
- **For Reporting Victims of Abuse, Neglect or Domestic Violence** to government authorities that are authorized by law to receive such information, including a social service or protective service agency.
- **For Health Oversight Activities** to a health oversight agency for activities authorized by law, such as licensure, governmental audits and fraud and abuse investigations.

- **For Judicial or Administrative Proceedings** such as in response to a court order, search warrant or subpoena.
- **For Law Enforcement Purposes.** We may disclose your health information to a law enforcement official for purposes such as providing limited information to locate a missing person or report a crime.
- **To Avoid a Serious Threat to Health or Safety** to you, another person or the public by, for example, disclosing information to public health agencies or law enforcement authorities, or in the event of an emergency or natural disaster.
- **For Specialized Government Functions** such as military and veteran activities, national security and intelligence activities, and the protective services for the President and others.
- **For Workers' Compensation** as authorized by, or to the extent necessary to comply with, state workers compensation laws that govern job-related injuries or illness.
- **For Research Purposes** such as research related to the evaluation of certain treatments or the prevention of disease or disability, if the research study meets privacy law requirements.
- **To Provide Information Regarding Decedents.** We may disclose information to a coroner or medical examiner to identify a deceased person, determine a cause of death, or as authorized by law. We may also disclose information to funeral directors as necessary to carry out their duties.
- **For Organ Procurement Purposes.** We may use or disclose information to entities that handle procurement, banking or transplantation of organs, eyes or tissue to facilitate donation and transplantation.
- **To Correctional Institutions or Law Enforcement Officials** if you are an inmate of a correctional institution or under the custody of a law enforcement official, but only if necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.
- **To Business Associates** that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. Our business associates are required, under contract with us, to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.
- **For Data Breach Notification Purposes.** We may use your contact information to provide legally-required notices of unauthorized acquisition, access, or disclosure of your health information. We may send notice directly to you or provide notice to the sponsor of your plan through which you receive coverage.

Additional Restrictions on Use and Disclosure

Certain federal and state laws may require special privacy protections that restrict the use and disclosure of certain health information, including highly confidential information about you. "Highly confidential information" may include confidential information under Federal laws governing alcohol and drug abuse information and genetic information as well as state laws that often protect the following types of information:

- HIV/AIDS;
- Mental health;
- Genetic tests;
- Alcohol and drug abuse;

- Sexually transmitted diseases and reproductive health information; and
- Child or adult abuse or neglect, including sexual assault.

If a use or disclosure of health information described above in this notice is prohibited or materially limited by other laws that apply to us, it is our intent to meet the requirements of the more stringent law. Attached to this notice is a summary of federal and state laws on use and disclosure of certain types of medical information.

Except for uses and disclosures described and limited as set forth in this notice, we will use and disclose your health information only with a written authorization from you. Once you give us authorization to release your health information, we cannot guarantee that the person to whom the information is provided will not disclose the information. You may take back or "revoke" your written authorization at anytime in writing, except if we have already acted based on your authorization. To find out where to mail your written authorization and how to revoke an authorization, contact the phone number listed on the back of your ID card.

What Are Your Rights

The following are your rights with respect to your health information:

- **You have the right to ask to restrict** uses or disclosures of your information for treatment, payment, or health care operations. You also have the right to ask to restrict disclosures to family members or to others who are involved in your health care or payment for your health care. We may also have policies on dependent access that authorize your dependents to request certain restrictions. **Please note that while we will try to honor your request and will permit requests consistent with our policies, we are not required to agree to any restriction.**
- **You have the right to ask to receive confidential communications** of information in a different manner or at a different place (for example, by sending information to a P.O. Box instead of your home address). We will accommodate reasonable requests where a disclosure of all or part of your health information otherwise could endanger you. We will accept verbal requests to receive confidential communications, but requests to modify or cancel a previous confidential communication request must be made in writing. Mail your request to the address listed below.
- **You have the right to see and obtain a copy** of health information that may be used to make decisions about you such as claims and case or medical management records. You also may in some cases receive a summary of this health information. You must make a written request to inspect and copy your health information. Mail your request to the address listed below. In certain limited circumstances, we may deny your request to inspect and copy your health information. We may charge a reasonable fee for any copies. If we deny your request, you have the right to have the denial reviewed. If we maintain an electronic health record containing your health information, when and if we are required by law, you will have the right to request that we send a copy of your health information in an electronic format to you or to a third party that you identify. We may charge a reasonable fee for sending the electronic copy of your health information.
- **You have the right to ask to amend** information we maintain about you if you believe the health information about you is wrong or incomplete. Your request must be in writing and provide the reasons for the requested amendment. Mail your request to the address listed below. If we deny your request, you may have a statement of your disagreement added to your health information.
- **You have the right to receive an accounting** of certain disclosures of your information made by us during the six years prior to your request. This accounting will not include disclosures of information made: (i) prior to April 14, 2003; (ii) for treatment, payment and health care operations purposes; (iii) to you or pursuant to your authorization; (iv) to correctional institutions or law enforcement officials; and (v) other disclosures for which federal law does not require us to provide an accounting.

- **You have the right to a paper copy of this notice**. You may ask for a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. You also may obtain a copy of this notice at our website, **www.myuhc.com**.

Exercising Your Rights

- **Contacting your Health Plan.** If you have any questions about this notice or want to exercise any of your rights, please call the toll-free phone number on the back of your ID card or you may contact the *UnitedHealth Group Customer Call Center* at 866-633-2446.
- **Submitting a Written Request.** Mail to us your written requests for modifying or cancelling a confidential communication, for copies of your records, or for amendments to your record, at the following address:

UnitedHealthcare

Customer Service - Privacy Unit

PO Box 740815

Atlanta, GA 30374-0815

- **Filing a Complaint.** If you believe your privacy rights have been violated, you may file a complaint with us at the address listed above.

You may also notify the *Secretary of the U.S. Department of Health and Human Services* of your complaint. We will not take any action against you for filing a complaint.

Financial Information Privacy Notice

This notice describes how financial information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

We** are committed to maintaining the confidentiality of your personal financial information. For the purposes of this notice, "personal financial information" means information about an enrollee or an applicant for health care coverage that identifies the individual, is not generally publicly available and is collected from the individual or is obtained in connection with providing health care coverage to the individual.

Information We Collect

We collect personal financial information about you from the following sources:

- Information we receive from you on applications or other forms, such as name, address, age, medical information and *Social Security* number.
- Information about your transactions with us, our affiliates or others, such as premium payment and claims history.
- Information from consumer reports.

Disclosure of Information

We do not disclose personal financial information about our enrollees or former enrollees to any third party, except as required or permitted by law. For example, in the course of our general business practices, we may, as permitted by law, disclose any of the personal financial information that we collect about you, without your authorization, to the following types of institutions:

- To our corporate affiliates, which include financial service providers, such as other insurers, and non-financial companies, such as data processors.
- To nonaffiliated companies for our everyday business purposes, such as to process your transactions, maintain your account(s), or respond to court orders and legal investigations.
- To nonaffiliated companies that perform services for us, including sending promotional communications on our behalf.

*For purposes of this Financial Information Privacy Notice, "we" or "us" refers to the entities listed on the first page of the **Health Plan Notices of Privacy Practices**, plus the following UnitedHealthcare affiliates: AmeriChoice Health Services, Inc.; DBP Services of New York IPA, Inc.; DCG Resource Options, LLC; Dental Benefit Providers, Inc.; Dental Benefit Providers of California, Inc.; Dental Benefit Providers of Illinois, Inc.; Disability Consulting Group, LLC; HealthAllies, Inc.; MAMSI Insurance Resources, LLC; Managed Physical Network, Inc.; Mid Atlantic Medical Services, LLC; National Pacific Dental, Inc.; Nevada Pacific Dental; OneNet PPO, LLC; Oxford Benefit Management, Inc.; Oxford Health Plans LLC; PacifiCare Health Plan Administrators, Inc.; ProcessWorks, Inc.; Spectera, Inc.; Spectera of New York, IPA, Inc.; UMR, Inc.; Unimerica Insurance Company; Unimerica Life Insurance Company of New York; Unison Administrative Services, LLC; United Behavioral Health of New York I.P.A., Inc.; United HealthCare Services, Inc.; UnitedHealth Advisors, LLC; UnitedHealthcare Service LLC; UnitedHealthcare Services Company of the River Valley, Inc.; UnitedHealthOne Agency, Inc. This Financial Information Privacy Notice only applies where required by law. Specifically, it does not apply to (1) health care insurance products offered in Nevada by Health Plan of Nevada, Inc. and Sierra Health and Life Insurance Company, Inc.; or (2) other UnitedHealth Group health plans in states that provide exceptions for HIPAA covered entities or health insurance products.*

Confidentiality and Security

We restrict access to personal financial information about you to our employees and service providers who are involved in administering your health care coverage and providing services to you. We maintain physical, electronic and procedural safeguards in compliance with state and federal standards to guard your personal financial information. We conduct regular audits to help ensure appropriate and secure handling and processing of our enrollees' information.

Questions about this Notice

If you have any questions about this notice, please call the toll-free phone number on the back of your ID card or you may contact the *UnitedHealth Group Customer Call Center* at 866-633-2446.

UnitedHealth Group

Health Plan Notice of Privacy Practices: Federal and State Amendments

The first part of this Notice, which provides our privacy practices for Medical Information, describes how we may use and disclose your health information under federal privacy rules. There are other laws that may limit our rights to use and disclose your health information beyond what we are allowed to do under the federal privacy rules. The purpose of the charts below is to:

- Show the categories of health information that are subject to these more restrictive laws.
- Give you a general summary of when we can use and disclose your health information without your consent.

If your written consent is required under the more restrictive laws, the consent must meet the particular rules of the applicable federal or state law.

Summary of Federal Laws

Alcohol & Drug Abuse Information
We are allowed to use and disclose alcohol and drug abuse information that is protected by federal law only (1) in certain limited circumstances, and/or disclose only (2) to specific recipients.
Genetic Information
We are not allowed to use genetic information for underwriting purposes.

Summary of State Laws

General Health Information	
We are allowed to disclose general health information only (1) under certain limited circumstances, and /or (2) to specific recipients.	CA, NE, PR, RI, VT, WA, WI
HMOs must give enrollees an opportunity to approve or refuse disclosures, subject to certain exceptions.	KY
You may be able to restrict certain electronic disclosures of health information.	NV
We are not allowed to use health information for certain purposes.	CA
We will not use and/or disclose information regarding certain public assistance programs except for certain purposes.	MO, NJ, SD
Prescriptions	
We are allowed to disclose prescription-related information only (1) under certain limited circumstances, and /or (2) to specific recipients.	ID, NH, NV

Communicable Diseases	
We are allowed to disclose communicable disease information only (1) under certain limited circumstances, and /or (2) to specific recipients.	AZ, IN, KS, MI, NV, OK
Sexually Transmitted Diseases and Reproductive Health	
We are allowed to disclose sexually transmitted disease and/or reproductive health information only (1) under certain limited circumstances and/or (2) to specific recipients.	CA, FL, HI, IN, KS, MI, MT, NJ, NV, PR, WA, WY
Alcohol and Drug Abuse	
We are allowed to use and disclose alcohol and drug abuse information (1) under certain limited circumstances, and/or disclose only (2) to specific recipients.	CT, GA, HI, KY, IL, IN, IA, LA, NC, NH, WA, WI
Disclosures of alcohol and drug abuse information may be restricted by the individual who is the subject of the information.	WA
Genetic Information	
We are not allowed to disclose genetic information without your written consent.	CA, CO, HI, IL, KS, KY, LA, NY, RI, TN, WY
We are allowed to disclose genetic information only (1) under certain limited circumstances and/or (2) to specific recipients.	AK, AZ, FL, GA, IA, MD, MA, MO, NJ, NV, NH, NM, OR, RI, TX, UT, VT
Restrictions apply to (1) the use, and/or (2) the retention of genetic information.	FL, GA, IA, LA, MD, NM, OH, UT, VA, VT
HIV / AIDS	
We are allowed to disclose HIV/AIDS-related information only (1) under certain limited circumstances and/or (2) to specific recipients.	AZ, AR, CA, CT, DE, FL, GA, HI, IA, IL, IN, KS, KY, ME, MI, MO, MT, NY, NC, NH, NM, NV, OR, PA, PR, RI, TX, VT, WA, WI, WV, WY
Certain restrictions apply to oral disclosures of HIV/AIDS-related information.	CT, FL
Mental Health	
We are allowed to disclose mental health information only (1) under certain limited circumstances and/or (2) to specific recipients.	CA, CT, DC, HI, IA, IL, IN, KY, MA, MI, NC, NM, PR, TN, WA, WI
Disclosures may be restricted by the individual who is the subject of the information.	WA
Certain restrictions apply to oral disclosures of mental health information.	CT
Certain restrictions apply to the use of mental health information.	ME

Child or Adult Abuse	
We are allowed to use and disclose child and/or adult abuse information only (1) under certain limited circumstances, and/or disclose only (2) to specific recipients.	AL, CO, IL, LA, NE, NJ, NM, RI, TN, TX, UT, WI

Statement of Employee Retirement Income Security Act of 1974 (ERISA) Rights

As a participant in the plan, you are entitled to certain rights and protections under the *Employee Retirement Income Security Act of 1974 (ERISA)*.

Receive Information about Your Plan and Benefits

You are entitled to examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the *U.S. Department of Labor* and available at the *Public Disclosure Room* of the *Employee Benefits Security Administration*.

You are entitled to obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated *Summary Plan Description*. The Plan Administrator may make a reasonable charge for the copies.

Continue Group Health Plan Coverage

You are entitled to continue health care coverage for yourself, spouse or Dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your Dependents may have to pay for such coverage. The Plan Sponsor is responsible for providing you notice of your *COBRA* continuation rights. Review the *Summary Plan Description* and the documents governing the plan on the rules governing your *COBRA* continuation coverage rights.

You are entitled to a reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another group health plan. You should be provided a certificate of creditable coverage, in writing, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect *COBRA* continuation coverage, when your *COBRA* continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. You may request a certificate of creditable coverage by calling the number on the back of your ID card. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, *ERISA* imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under *ERISA*.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. Under *ERISA*, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the

materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for Benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the *U.S. Department of Labor*, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under *ERISA*, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the *Employee Benefits Security Administration*, *U. S. Department of Labor* listed in your telephone directory or the *Division of Technical Assistance and Inquiries*, *Employee Benefits Security Administration*, *U.S. Department of Labor*, 200 Constitution Avenue, N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under *ERISA* by calling the publication hotline of the *Employee Benefits Security Administration*.

ERISA Statement

If the Enrolling Group is subject to ERISA, the following information applies to you.

Summary Plan Description

Name of Plan: Insperity Group Health Plan

Name, Address and Telephone Number of Plan Sponsor and Named Fiduciary:

Insperity Holdings, Inc.
19001 Crescent Springs Drive
Kingwood, TX 77339-3802
(866) 715-3552

The Plan Sponsor retains all fiduciary responsibilities with respect to the Plan except to the extent the Plan Sponsor has delegated or allocated to other persons or entities one or more fiduciary responsibility with respect to the Plan.

Claims Fiduciary:

UnitedHealthcare Insurance Company

Employer Identification Number (EIN): 76-0178498

IRS Plan Number: 502

Effective Date of Plan: The effective date of the Plan is January 1, 2002; the effective date of this restatement of the Plan is January 1, 2013

Type of Plan: Health care coverage plan

Name, business address, and business telephone number of Plan Administrator:

Insperity Holdings, Inc.
19001 Crescent Springs Drive
Kingwood, TX 77339-3802
(866) 715-3552

Type of Administration of the Plan:

Benefits are paid pursuant to the terms of a group health policy issued and insured by:

UnitedHealthcare Insurance Company
185 Asylum Street
Hartford, CT 06103-3408

The Plan is administered on behalf of the Plan Administrator by UnitedHealthcare Insurance Company pursuant to the terms of the group Policy. UnitedHealthcare Insurance Company provides administrative services for the Plan including claims processing, claims payment, and handling appeals.

Person designated as agent for service of legal process: Plan Administrator:

Source of contributions and funding under the Plan: There are no contributions to the Plan. Any required employee contributions are used to partially reimburse the Plan Sponsor for Premiums under the Plan. Benefits under the Plan are funded by the payment of Premium required by the group Policy.

Method of calculating the amount of contribution: Employee-required contributions to the Plan Sponsor are the employee's share of costs as determined by Plan Sponsor. From time to time, the Plan Sponsor will determine the required employee contributions for reimbursement to the Plan Sponsor and distribute a schedule of such required contributions to employees.

Date of the end of the year for purposes of maintaining Plan's fiscal records:

Plan year shall be a 12 month period ending December 31.

Determinations of Qualified Medical Child Support Orders: The plan's procedures for handling qualified medical child support orders are available without charge upon request to the Plan Administrator.